Torbay and South Devon NHS Foundation Trust

TSDFT Board of Directors

Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital, TQ2 7AA

25 May 2016 13:30

AGENDA

1 Recipient Story

Owner : Ch

2 PART A: Matters for Discussion/Decision

2.1 Apologies for Absence - Chief Nurse

Owner : Ch

Note

2.2 Declaration of Interests

Owner : Ch

Note

2.3 Minutes of the Board Meeting held on the 4th May and Outstanding Actions

Owner : Ch

Approve

2.4 Report of the Chairman

Owner : Ch

Note

2.5 Report of the Chief Executive

Owner : CE

Assurance

2.6 Strategic Issues

2.6.1 Bay Tree House - Progress

Owner : COO

Assurance

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2.6.2 St Kilda

Owner : COO

Assurance

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2.6.3 Urgent Care Improvement Plan Update

Owner : COO

Assurance

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2.7 Quality and Safety Exception Reporting including Activity and Performance

Owner : COO/CN

Assurance

Quality and Performance Report.pdf 63

2.8 Governors' Questions

Owner : Ch

2.9 Any Other Items Requiring Discussion/Decision (including periodic items eg annual reports and BAF)

2.9.1 Annual Infection Prevention and Control Report 2015/16 and Annual Plan 2016/17

Owner : CN

Assurance

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3 PART B: Matters for Approval/Noting Without Discussion

3.1 Reports from Board Committees

Assurance

3.2 Reports from Executive Directors

3.2.1 Report of the Chief Operating Officer

Owner : COO

Assurance

3.2.2 Report of the Interim Director of Human Resources

Owner : IDHR

Assurance

3.2.3 Report of the Director of Estates and Commercial Development

Owner : DECD

Assurance

3.3 Compliance Issues

3.4 Any Other Business Notified in Advance

Owner : Ch

3.5 Dates of Next Meeting - 9.00 am, Wednesday 1st July 2016

Owner : Ch

3.6 Exclusion of the Public

Owner : Ch

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST BOARD OF DIRECTORS MEETING HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE, TORBAY HOSPITAL ON WEDNESDAY 4TH MAY 2016

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr J Furse	Non-Executive Director
	Mrs J Lyttle	Non-Executive Director
	Mrs J Marshall	Non-Executive Director (part)
	Mr R Sutton	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	Mr J Welch	Non-Executive Director
	Mrs M McAlinden	Chief Executive
	Mr P Cooper	Director of Finance
	Mrs L Darke	Director of Estates and Commercial Development
	Ms L Davenport	Chief Operating Officer
	Dr R Dyer	Medical Director
	Councillor J Parrott	Torbay Council Representative
	Mrs J Viner	Chief Nurse
In Attendance:	Mrs C Farrell	Head of Communications
	Mrs S Fox	Board Secretary
	Mrs S Machin	DGM, Medicine
	Mr R Scott	Corporate Secretary

Mrs C French	Lead Governor	Mrs C Carpenter	Governor
Mr C Davidson	Governor	Mrs A Hall	Governor
Ms B Inger	Governor	Mrs M Lewis	Governor

ACTION

PART A: Matters for Discussion/Decision

50/05/16 **Apologies**

Apologies were received from the Director of Strategy and Improvement and the Interim Director of Human Resources.

51/05/15 **Declarations of Interest**

Nil.

52/05/16 **Minutes of the Board Meeting held on the 6th April 2016 and Outstanding Actions**

The minutes were approved as an accurate record of the meeting held on the 6th April 2016.

53/05/16 **Report of the Chairman**

The Chairman highlighted the following:

- **CQC report** – the Trust had received the draft report from the CQC and was reviewing it for factual accuracy. The report would be shared as soon as the CQC gave the Trust permission to do so – at present the CQC had requested a limited circulation as it was not the final version.

- **Finance and Contract Negotiations** – these were ongoing and the Chairman asked the Board to keep this delay in agreeing the contract for 2016/17 in context as the Trust was in the same position as many other Trusts in trying to resolve contract negotiations.

- **Community Service Transformation – Public Consultation and Engagement** – the Chairman assured the meeting that Governors and staff would be engaged in the public consultation process as soon as it commenced. He reminded the meeting the CCG was leading this process and had only approved the consultation proposals at its Governing Body last week and that the public consultation was scheduled to commence on the 13th May. The Chief Executive subsequently advised that this date could be delayed due to the NHSE Gateway process.

- **Junior Doctors' Strike** – the Chairman wished to place on record his thanks, and that of the Board, for the manner in which the consultant body, administration teams, health care professionals and executives have managed the junior doctor strike in such a careful and thoughtful manner.

- **Nurse Recruitment Drive** – a successful nurse recruitment drive had been recently held in the Horizon Centre. The Chairman highlighted the fact that the Bay had a high calibre resource to draw on, along with universities in the area and also the Trust had a good record as a training and teaching hospital.

- **Director of Human Resources and Organisational Development** – Judy Saunders had accepted the appointment and would commence on the 1st August.

54/05/16 **Report of the Chief Executive**

The Chief Executive, in her report, confirmed that the body of the missing Junior Doctor had been recovered and reflected the Trust's sympathies to the family. She also further updated the Board on the receipt of the draft CQC report, which was being checked for factual accuracy; action being taken to progress the ED Recovery Plan; and the Junior Doctors' Strike.

The Chief Executive briefed the Board on the contract negotiations for 2016/17 and that a meeting had been held earlier in the week with NHSE, NHS Improvement (NHSI) and the CCG where a full and frank discussion was held around the issues delaying contract settlement. The Trust and CCG were encouraged to enter into the arbitration process and was also informed that there was little prospect of external support from the NHSE or NHSI due to the wider financial difficulties across the NHS and locally in the South West. The Board would be kept appraised of progress.

Mr Welch queried the statement in the Chief Executive's report in respect of North Devon Care Homes and the fact that North Devon Hospitals had taken on the role as the main contractor to manage care providers to ensure quality and consistency of service. He queried why they might wish to do this. The Chief Executive said that she did not have detailed information on the reasons behind this move, but would try to get some to fully answer this question. She added that the living wage requirement

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had reassessed the cost between the NHS and the independent sector.

Councillor Parrott raised concern in respect of the time it might take NHSE to make their decision around the gateway process in terms of the Community Services consultation and the fact that this would increase uncertainly and could be destabilising. The Chief Executive agreed, and confirmed NHSE had been urged to make a decision as soon as possible.

Strategic Issues

55/05/16 **Community Services Transformation: Reconfiguration Consultation Update**

Transforming community services lie at the heart of the ICO's vision of health and care. The report provided an update to Board on the latest position with regard to the strategic proposals and public consultation.

The change proposals were the next stage in progressing towards the new care model across all localities and follow an earlier CCG consultation on service changes in the Coastal locality which are in the process of being implemented.

Responsibility for conducting the statutory three month public consultation on reconfiguration of services lies with South Devon and Torbay CCG. At its meeting of 28 April, the CCG's Governing Body approved proposals to change NHS resources from bed-based hospital care to enhanced community services that will better support people within their local communities, in or as close to their homes as possible.

In summary, the core changes proposed as a basis for public consultation included:

- Increased investment (£3.9m) in community based services to provide improved out of hospital services through a clinical hub in each locality, health and wellbeing, teams within the main town areas, co-located where possible with local GP services;
- Expansion of community services including the private sector care home/intermediate care market;
- Closure of four community hospitals - Ashburton and Buckfastleigh, Bovey Tracey, Dartmouth and Paignton;
- Reduction of MIUs by closing Ashburton (currently suspended), Brixham, Dartmouth, (currently suspended) Paignton. Three remaining MIUs Totnes, Newton Abbot and (in coastal) Dawlish would open 8 am to 8 pm, seven days a week and have diagnostics.

Final approval to proceed to consultation was with NHS England who were considering the proposals at a Gateway assurance panel next month to check the plans meet the Government's 4 reconfiguration tests.

Subject to above approval to proceed, the CCG plan to run the public consultation from 13 May to 5 August 2016 (now confirmed as delayed).

Risks to the process included:

- Delays in approval to proceed would push back the consultation process. This would delay the final decision making process with impact on implementation which meant delay in benefits realisation and associated funding for the development of community services.

- Outcome of public consultation might not support the changes – with associated impact to implementation of the care model changes.
- Staff confidence and capability to adopt new ways of working.
- Securing 'fit for purpose' accommodation for co-location/nearside location of Health & Wellbeing Teams with local GP services.
- Stimulating sufficient independent sector capacity to support new model.

Mr Allen asked if the Trust had obtained its own legal advice in terms of the process and risk of judicial review. The Chief Operating Officer said that it had not but undertook to do so. She added that the CCG, as the lead, had sought legal advice. LDv

Mr Welch stated that the Trust needed to learn from the difficult Ashburton and Buckfastleigh consultation that took place several years ago, and ensure communities understood the rationale behind the consultation proposals.

Mr Welch then asked if there were plans to rationalise the use of Castle Circus Health Centre and the Director of Estates and Commercial Development stated that the Centre was included as part of the work looking at outpatient flows throughout the whole system and the services provided there. For example, there were plans to consolidate dental services in Newton Abbot.

Mr Furse queried the private sector care home and intermediate care home market and the views of the public receiving the same or similar care and how innovative the Trust's role was as a co-provider of care. The Chief Executive said that two issues were emerging as part of the pre-consultation process, once was a general issue about confidence in the quality of services in care sector and the second was the confidence in the ability of the care sector to respond to additional demand. To this end, the CCG had been asked to seek 'without prejudice' general expressions of interest from the market.

Councillor Parrott stated that, as a commissioner, the Council would do what it could to cultivate the market and as part of that held regular multi-provider forums which all providers attended and he suggested that the CCG be invited to attend these meetings. LDv

The Chairman stressed the need for good communication and said he was concerned about the timing of the consultation process, given other pressures currently facing the CCG. Mrs Lyttle raised a concern around the resource in the Trust's Communications Team and if the need for them to be able to manage the communication around this consultation effectively. The Chief Executive said that the Director of Strategy and Improvement now led the Communications Team and said that she would also be working closely with the Communications Team in the CCG to ensure the work related to the consultation was given the necessary priority.

Mrs Taylor highlighted a report that had been published around the fact that one in four care homes was failing and what the Trust could do to counteract that, given one its key arguments was to use the private and independent sector more effectively. The Chief Executive said that the Council market development was intended to provide a stable, high performing sector.

The Board formally received and noted the content of the report

56/05/16 **Bay Tree House – Progress**

The Board and Torbay Council's Overview and Scrutiny Committee had requested a progress update as further assurance on the availability, suitability and cost of the alternative private sector provision before the decision to close Bay Tree House in

June 2016 was implemented. This report detailed the progress that had been made to date with the 39 current service users and their families/carers. Trust officials had been asked to attend a meeting of the overview and Scrutiny Committee on 18 May 2016 to provide similar assurance.

At this mid-point in the process between the Board decision in early March and the target date to complete the work of 30th June, approximately half the service users' alternative provision had been resolved or were close to resolution. The risks to achieving the proposed closure date were:

- Ensuring appropriate engagement with clients, families and carers on how available alternatives will/are meeting their needs to provide sufficient assurance to the Overview and Scrutiny Committee at the meeting on 18 May.

- Securing and agreeing suitable alternative provision for all current service users in advance of planned closure date.

Councillor Parrott informed the meeting that members of the Council would be shortly visiting the new facility to gain assurance that it was appropriate to deliver the service needed. The Chief Operating Officer said that it was helpful that families could visit the facilities being offered by alternative providers to help provide assurance around their suitability.

Mr Welch asked if anyone was choosing not to engage and the Chief Operating Officer said that the involvement of HealthWatch had been really important in helping with the engagement process, and that also Mr Helmore, who was the lead in the 'Save Baytree House' campaign had also provided clear options for those families who had not been engaging.

Mrs Lyttle said that she felt the consultation process was one that should be used as a blueprint for the future as it had been a robust process with all stakeholders involved in the journey.

The Board confirmed it was assured that the consultation process was being managed in an appropriate and timely manner.

57/05/16 **Care Model Investments**

The Board of Directors approved a proposal to invest a total of £3.9 million in the implementation of the care model as described in the ICO Business case. The Care Model Executive had considered the priorities for investment in 2016/17 and the report sets out the proposed areas of expenditure for Board of Directors consideration and approval.

Risks to the expenditure include:

- Public Consultation process and potential of the outcome to change the final configuration of community services;

- Sustainability of current community services model in the short term;

- Voluntary sector and care home sector sustainability while care model changes are implemented; and

- Protecting the proposed investments given financial pressures.

The Board noted that the priorities would enable the Trust to move forward with the care model plans and would strengthen community services and intermediate care and move to new ways of working with clinical hubs. It would ensure a greater level

of resilience in the future.

Mr Allen said that the proposals were in line with what the Trust was trying to achieve and so the proposals had his full approval. Mrs Lyttle echoed Mr Allen's view.

Mr Furse asked whether, as a significant proportion of the spend was on staffing, the Trust would be able to fill the proposed posts. The Chief Operating Officer said that there was an element of the staffing requirement that would be new, but that existing staff would be retrained to enable them to move into the new roles. It was noted that the staff in Paignton Hospital, who were already approaching the changes in a very realistic way, had suggested visits for staff already working in these new roles to build confidence. The engagement of staff in this process was very important so that the Trust did not lose talented staff as a result of the changes.

The Director of Finance stated that the plans were around investing to save money in the future, and managing cost in the longer term, and this was acknowledged.

The Board formally approved the proposed investment priorities for the development of the Care Model for 2016/17

58/05/16 **Sustainability and Transformation Plan (STP) Update**

The report updated the Board on the development of the Wider Devon Sustainability and Transformation Plan (STP) and the ICO's role within that set against the context of the Five Year Forward View and access to sustainability and transformation funding, local health economy place based plans and the ICO's 5 year integrated business plan.

STP footprints were required to submit final STPs by the end of June 2016.

Risks to this process included:

- Involvement in wider footprint had potential to impact on local plans;
- Alignment of Wider Devon STP and the New Devon Success Regime needed to be clear – the ICO and the South Devon and Torbay health and care economy were part of the STP but not in the NEW Devon Success Regime;
- A need to ensure South Devon and Torbay health and care economy had a strong voice in the STP planning and governance arrangements and maximised the opportunities of being involved;
- Releasing capacity to engage in another layer of planning and to respond to extensive data requests; and
- Failure to produce (and then implement) an ambitious yet realistic and affordable STP might have a significant financial impact on the local health and care economy including the ICO as it was tied to sustainability and transformation fund allocations.

Mr Furse said that it was important the Trust's voice was heard as part of the STP plans. The Chief Executive agreed and said that she, along with the CCG Chief Clinical Officer, had been invited to join the STP Chief Executives' Group as part of the governance structure. In addition she had agreed that Ann Wagner would provide resource to the STP Team for one day a week, along with some Band 8 support. The fact that the Trust, as an ICO, was almost as big as the RD&E and Derriford, and was known for its innovation, was noted.

The Board formally noted the contents of the report.

59/05/16 **Quality and Safety Exception Reporting including Activity and Performance**

The integrated Quality, Performance and Finance Report provided the assessment of the Trust's position for the fourth quarter of 2015/16 and the 12 month period to the year ended 31st March 2016. The Monitor license and the contract performance requirements were reported on. Areas of under-delivery or at risk of not delivering are identified and associated action plans were reported.

The report had been considered by the Finance and Performance Committee. In addition each Service Delivery Unit meets with Executives to provide assurance and agree improvement.

Due to the heightened concerns regarding patients' experience and performance in the Emergency Department, further assurance processes were in place. These included weekly executive-led improvement meetings with commissioner attendance. In addition the Trust's Executives meet weekly with CCG colleagues to provide further assurance.

In response to significant concerns regarding Emergency Department performance and quality, the Trust received a CQC Requirement Notice on 10 March 2016. The Trust response was set out in a comprehensive action plan that was being monitored through the processes set out in the report.

The year-end position showed a £10.37m deficit against a plan of £7.4m based on Monitor's financial assessment. This excluded ICO transition costs, restructuring costs and the additional income received £2.5m from NHS England. The variance to plan of £2.9m was mainly due to the NHS England income being agreed after the latest plan submission December 2015, and was therefore not included.

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The CIP target was £15.3m of which £13.1m has been delivered in year. The CIP delivered recurrently was £3M leaving £10.1M to be added to the challenge for 2016/17.

Risks to performance included:

- Patient experience in the Emergency Department and delivery of the associated 4 hour standard;
- Referral to Treatment, proportion of patients waiting under 18 weeks;
- The number of follow up patients waiting beyond their recommended appointment date; and
- Securing deliverable plans to cover the value of CIP carried forward into 2016/17.

The following was noted:

- There was a data error in respect of pressure ulcers, in respect of Grade 3 and 4 ulcers, and the correct information would be provided once the data had been verified. It was noted that pressure ulcers were a significant and reliable indicator of quality and the Trust had not experienced any significant incidents over the period covered by the report. There had been an increase in pressure ulcers in the Emergency Department in February, and these were being investigated. Two had been closed and three of them were likely to have been present when patients were admitted. The Chairman asked if the numbers were statistically significant or not, and the Chief Nurse said that she looked for trends and that it was not significant. Mr Welch said that there had been a drive to reduce the numbers of pressure ulcers in community hospitals, which was around changing the attitude of staff and this had been

successful. The Chief Nurse acknowledged this and said that staff did take the matter seriously and that their attitudes did make a huge difference.

- Mr Welch expressed concern in respect of a number of areas of performance, including VTE; community medication errors; and fractured neck of femur. He suggested that if the CQC had not focussed on ED performance, they might have picked up on other performance issues. The Medical Director acknowledged the fractured neck of femur poor performance and said that this was one of a number of indicators used to assess the patient outcome and was one that the Trust was required to report. He said that the Trust's mortality outcome in terms of fractured neck of femur was lower than the national average, for example. It was agreed that the performance report needed to include information so that performance could be triangulated against other performance markets so that trends could be identified, and grouping targets and background information together. An example was ED performance with a strong alignment between the 4 hour wait, trolley waits over 12 hours and poor ambulance handover times. DoF/DSI/ COO

- The role of the Quality Assurance Committee (QAC) was important in this respect, to look at the detail behind performance and provide assurance to the Board. Mr Allen, as Chair of QAC, said that the Committee needed to have the appropriate resource to undertake this role, in a similar way to the Audit and Assurance Committee.

- Mrs Taylor raised a concern in respect of the Dementia Find and Assess target. The Chief Nurse said that the reason this target had not been met was because of difficulties in using a part paper, part electronic system and the process not matching workflow – it was not because the assessment was not done in a timely manner. The Nervecentre IT system was coming on line in June and would provide the ability to input the assessment as soon it was completed.

- Mrs Taylor said she was concerned that there appeared to be evidence that systems was not as robust as they could be, and that record keeping was not as good as practice suggested – for example in respect of pressure ulcers. The Chief Nurse responded and said that two years ago she would have agreed, however in the main this was not now the case, although there were some areas that still needed addressing.

- RTT performance, although only just below target, was ahead of trajectory. It did, however, mask some underlying risks areas, in particular in respect of follow ups and need to balance RTT with capacity to manage follow ups. There were also risks in Neurology due to a significant number of vacancies and a lack of external providers. The Trust was working closely with the CCG to look at alternative providers and if not resolved would be a material risk to RTT compliance.

- The number of operations cancelled was at 1% against a national target of 0.8% and reflected the pressure in the wider system and access to ITU capacity over the last couple of months.

- There continued to be concern in respect of adult safeguarding and the need for a strategy meeting within seven days of referral. This was a local target and was a process indicator, and it was planned to move towards outcome targets in the future, to provide stakeholders with meaningful indicators.

- The Trust was also working with the CCG on CAMHS to secure a longer-term commitment to the service so that it could be managed in a sustainable manner, rather than the use of agency staffing. It was noted that, although the time to the strategy meeting took longer than seven days, all referrals

were assessed and needs understood. The sustainability of the CAMHS service was an area of concern as it was a small team and could not cope with variations due to staff being absent or vacancies, align with increased in referrals. The Trust was exploring the possibility of a partnership with Virgin Healthcare, who run the CAMHS service for Devon and scoping work was currently being undertaken. Councillor Parrott asked for assurance that the backlog was reducing and it was agreed a deep dive would be undertaken by the Quality Assurance Committee and that Councillor Parrott be invited to attend that meeting. LDv/DA

- Mrs Lyttle raised a concern in respect of timely outpatient reviews and the Medical Director said that it was always a balance for departments to manage in terms of the seeing a patient for the first time and follow up appointments. He said that in some respects it was more dangerous to not see a patient for a follow up appointment in a timely manner, who was having active treatment, compared to a patient for the first time with a minor condition. He said that departments dealt with this issue in many different ways and he felt that a standard process was required and this work was being undertaken through the Quality Improvement Group.

- The Medical Director responded to Mr Welch's concern raised earlier in the meeting in respect of medicine errors and stressed the number of medication procedures that took place on a daily basis across the ICO and the culture of reporting minor errors that did not cause harm. He added that there was evidence that showed where minor errors were reported the incident of major errors that caused harm was reduced.

- The production of timely discharge summaries remained an issue, however performance had improved with the introduction of the ED IT system, and the Trust had received positive feedback from primary care. Action to make further improvements would be managed through the Quality Improvement Group.

- The Trust's financial position was broadly in line with plan. Monitor had informed the Trust, after the plan had been submitted, that the £2.5m of additional support could not be included in the Trust's reporting, so this would show as a variance. It did not affect the Trust's risk rating, but did mark the Trust down as not achieving its plan.

- There had been significant moves in Income and Expenditure due to receipt and payment of backdated care home fees.

- Mr Furse queried the £12m impairment in respect of the Care Trust and the Director of Finance explained that this was a process that was undertaken every year where the Trust's assets were revalued by the District Auditor. He added that it had also been agreed with Grant Thornton and PwC.

- Mr Welch queried the fact that the Trust's nursing agency spend was above the 4% national cap. the Chief Nurse explained that this was because at the time the cap was put in place the Trust had its overflow ward open and that spend was now steadily decreasing. She added that Monitor had been kept fully aware of the Trust's situation, and in particular the fact that none of the providers on Monitor's approved list of agency providers operated in the South West. In addition, weekly returns were made to Monitor in terms of agency usage and the process the Trust employed to approve the use of agency staff.

60/05/16 **Governors' Questions**

- Mrs French congratulated the Trust on the national profile its Trauma and Triage Service had received.

- Mrs French stressed the need for the Trust to ensure that communication around the community hospital consultation process was robust so that communities understood the need to close hospitals and that services would be re-provided elsewhere in the community. She added that communities who had originally purchased hospitals might feel that they should receive the proceeds of any sale.

- It terms of the sale of hospitals, it was noted that the Trust owned them, with no covenants attached, and that the delivery of the care model detailed how the proceeds of any sales would be used to provide fit for purpose estate to redeliver services in a different way in the community. It was agreed that communication with communities needed to be robust and that the reasons behind the proposed closures clearly defined. It was noted that the Trust could not prejudice the outcome of the consultation process in any communication with communities. The Chief Executive added that as part of the model the Trust needed to work with the local communities to look at the use of hospitals, if they could effectively be used for any other purpose; the availability of the care sector; and also availability of travel options for services not provided locally.

- It was agreed that the Director of Easters and Commercial Development give a presentation at the next Council of Governors on the Trust's Estates Strategy and in particular around the condition of the community hospitals etc. — CS/ DECD

- Mrs Carpenter asked if the Trust knew when the consultation meetings would be held and the Chairman explained that the process was CCG-led and that they were currently working on the timetable etc.

Any Other Items Requiring Discussion/Decision (including periodic items)

61/05/16 **Quality Account 2015/16**

The priorities identified for this year linked to the strategic priorities of the Trust and had been agreed with stakeholders. They were ambitious and there was the risk of delay in delivery but the teams responsible for delivery had clear action plans with progress milestones. Progress would be monitored by the Quality Improvement Group and to the Quality Assurance Group.

The Board approved the report to go to stakeholders prior to final sign off at the next Board meeting.

PART B: Matters for Approving/Noting without Discussion

62/05/16 **Reports from Board Committees – Quality Assurance Committee Chair Report**

The following issues were highlighted:

1. Community Infection Control Visits

Following a query from Non-Executive Director Mr Jon Welch to the Chief Executive of the Trust, the Committee received a report from the Director of Infection Control, Dr Selina Hoque as to why community infection and prevention control nurses no longer routinely visited all patients diagnosed with C.difficile, as was the case with the former Care Trust.

Dr Hoque attended the Committee with a colleague and explained that the visits were tying up a lot of resource for no discernible benefit, according to the evidence presented to the Committee. Nurses had visited some 100 patients who had acquired C.difficile at home, but with no effect on the incidence of the infection. The time saved had been diverted into developing an infection, prevention and control protocol with much wider and consistent application than the previous arrangements.

The Committee noted in particular the follow up with GPs for every case of C.difficile in the community, the clear advice on prescribing and management issued to GPs and the patient safety leaflet issued via GPs to patients, relatives and carers.

The primary care community had been involved with and supported the changes. Dr Hoque and a colleague kindly attended the Committee meeting and explained the new arrangements in detail as well as responding to queries.

The QAC was assured that the new systematic, consistent arrangements were a better use of scarce resources than the previous arrangements and is grateful to Mr Welch for raising the issue and to the infection control team for their response.

2. Community Nursing Activity

A key concern of QAC was the quality and accuracy of data since the whole system of assurance relied on accurate and timely information. In this context the Committee considered an internal audit report on data quality in community nursing. Although the overall assurance opinion was amber and the overall risk low, the report highlighted a disconnect between reported activity through the PARIS system (IT system) of recording and actual visits undertaken in Torbay ie of a total 1,585 visits undertaken during a week last July only 835 were recorded on PARIS. Data quality is becoming a recurring theme for the Committee and is one where members felt considerable value could be added through its work.

3. Referral to Treatment (RTT)

The Committee received an verbal update from the Chief Operating Officer on RTT, including areas where performance was improving eg stroke and fractured neck of femur and areas of continuing challenge such as Ophthalmology and Orthopaedics.

4. Symphony IT system

The Committee considered the implementation and parameters of the system. There had been a significant dip in Emergency Department performance when the system was introduced in July 2015 which had yet to be recovered. A major defect in the system was the recording of patient observations ie it could only record the time of entry of the data by clinicians into the system, rather than the time the observations were actually carried out. That was to say, for example, that if blood pressure was taken at 20:00 but the reading not entered until 21:30 the system would record the reading as having been taken at 21:30 rather than 20:00. This distorted the real position and made it difficult for third parties looking at the data to use it for target compliance or management information. Given that clinicians were usually too busy treating patients (quite rightly) rather than entering real time data there were significant lags in the data which did not reflect the actual position. Members wondered why a system could have been specified with such an obvious shortcoming and QAC would wish to be assured that the system would be amended to make it possible to enter the actual time observations were made, but also had a wider concern about the quality of project specification and development which it would wish to pursue.

4. Safeguarding

The Committee considered a report from the Chief Nurse around statutory compliance with safeguarding legislation and the challenges of staff shortages and increasing demand. The Committee agreed that the current arrangements should be audited with a view to identifying any gaps and providing assurance or otherwise of statutory compliance.

Reports from Executive Directors

63/05/16 **Report of the Chief Nurse**

Reducing the incidence of pressure ulcers was a key strategic aim of the Trust and good progress has been made. In February however an increase in pressure ulcers was reported in the Emergency Department where there were five grade one to four ulcers. In line with Trust policy, staff made a referral to the safeguarding team. Investigation into each of these incidents was underway and a report was expected shortly. Initial review highlighted a failure to undertake an initial risk assessment and examination of the skin at admission to the Emergency Department to ascertain whether the patient was admitted with the ulcer. Update training has been provided to the ED team. A further issue related to the care of heels for those experiencing delays. A rapid review of practice was initiated and action to mitigate the risk put in place. Progress on the action plan will be monitored through the Quality Improvement Group.

A patient fall from an ED trolley resulting in serious injury was reported in March. This was reported to the Safeguarding Team and was being investigated with oversight from an external and independent investigator. The patient and family were receiving support and were engaged in the investigation process.

The CQC identified a number of Emergency Department quality measures that were being monitored through the Trust Urgent Care Improvement and Assurance Group. Whilst a number of metrics had improved, performance was variable and there were ongoing concerns about data accuracy. The Urgent Care Improvement and Assurance Committee (UCIAC) were reviewing these measures weekly to refine the data set and support clinical staff to achieve the best performance.

It was critical to ascertain the origin and cause of the pressure ulcers and the patient fall to better understand all possible links to ED pressure and effectiveness of risk management. The safeguarding investigation team would include this dimension in the investigation.

The Symphony System was being refined to ensure quality performance data was accurate and timely in order for The Trust to be confident in the data and processes and that it informed the right service changes to deliver sustained improvement. The ED team were wholly committed to this aim and were supported by the Service Transformation team on rapid cycle tests of change.

64/05/16 **Six Month Safe Staffing Report**

Over the last 18 months the Trust had undertaken a comprehensive programme of work to ensure best practice guidance set out by the National Quality Board (2013) and by the National Institute for Health and Care Excellence (NICE) (2014) for safe staffing in acute ward settings were met. Reported previously to the Finance Committee and the Board were the methods used to determine safe staffing establishment and actions underway to set and maintain appropriate staffing levels. This included:

- Shelford Safe Staffing Tools
- Professional Judgement

- Profession body guidance e.g. Royal College of Nursing

In July 2014 an interim Associate Director of Nursing and a Service Improvement Lead were appointed to focus exclusively on this work. In the last six months this investment has enabled detailed examination of the evidence and review of the Trust's current position.

In March the nursing workforce group identified five wards (Dunlop/Simpson/ Cheetham/Hill/George Earl and Ainslee) which appeared to be outside the RCN guidance of 60% Registered and 40% skilled not registered. Meetings had been held between the Chief Nurse, Associate Nurse Directors and Matrons to identify plans to explore and mitigate this position.

Patient dependency and acuity were increasing as the local population ages. In order to meet this demand the Trust needed to ensure it had a health and social care workforce competent to meet the complex needs of the local population. Recruitment of the nursing workforce to meet this need presented a significant challenge for the Trust.

Retirement was likely to have a significant impact on staffing over the next 5 years with 42% of registered nursing staff eligible to retire. This would require the recruitment of 150 staff over the next five years.

65/05/16 **Report of the Medical Director**

The Board noted that the junior doctors industrial action continues and an all-out strike took place on 2 days, 26th-27th April 2016.

It was noted that:

- Trust staff have managed the emergency care strikes to date without significant incident and with minimal disruption to patients;
- The strikes continued to be the cause of inconvenience and distress to some patients;
- The 'all-out' strike was associated with greater disruption to normal activity. Increased risk to patients was recognised and mitigating plans put in place;
- The strike period was managed efficiently and safely by senior medical staff and other supporting staff. There was no adverse incident other than inconvenience to patients; and
- Emergency care performance was excellent through the period of the strike.

66/05/16 **Report of the Chief Operating Officer**

The report sets out progress against key delivery objectives of the Trust including implementation of the planned care model changes and compliance with delivery against the Urgent Care Improvement plan. Risks to performance include:

- Clinical capacity to support delivery of plans;
- Environmental challenges; and
- Lack of consistent improvement in trajectory of 4 hour performance.

67/05/16 **Compliance Issues**

Nil.

68/05/16 **Any Other Business Notified in Advance**

Nil.

69/05/16 **Date of Next Meeting** – 1.30 pm, Wednesday 25th May 2016

Exclusion of the Public

It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
1.	Performance – paper to be brought to a future meeting in respect of Cardiology performance.	COO	**Update 6/4: COO advised of improved performance though not yet at 92% RTT. Revised guidance expected shortly – COO would bring paper to update Board**	6/04/16
2.	Junior Doctors contract **–** CEO to write stating Trust's position	CE	**Completed - Dr Dyer confirmed with the Junior Doctor Mess President that their letter had been discussed at the Board meeting. Given the current status of the contract negotiations, it is considered not necessary to formally respond, and Dr Dyer will communicate this to the Mess President.**	06/04/16
3.	Update to be provided on progress to improve clinical supervision performance.	CN	**Update 6/4:CN advised secondment had started, with work beginning with ED and CN would bring progress report to June Board. Now to be presented to the July Board.**	03/02/16
4.	CE to investigate reasons behind North Devon Hospitals taking on role of main contractor for North Devon Homes.	CE	**Completed - Information circulated to Board members.**	04/05/16
5.	Legal advice in respect of the Community Services Transformation consultation process to be sought.	COO	**Completed.**	04/05/16
6.	CCG be invited to attend Council-led multi-provider forums.	LDv	**Completed.**	04/05/16
7.	Format of performance report to be redesigned to include triangulation and background information to targets.	DoF/DSI/COO	**Completed - new format to be ready for the July Board.**	04/05/16

8.	Councillor Parrott to be invited to QAC when the CAMHS deep dive was considered.	LDv/DA	**Completed.**	04/05/16
9.	Director of Estates and Commercial Development to give presentation at next CoG on the Trust's Estates Strategy.	CS/DECD	**Completed – scheduled for the Council of Governor's meetingon the 20th July.**	04/05/16

Report to:	Trust Board
Date:	25 May 2016
Report From:	Mairead McAlinden, Chief Executive
Report Title:	Chief Executive's Business Report

Dr David Sinclair

It is with much sadness that I inform the Board that our hugely respected colleague, Dr David Sinclair, passed away on Sunday 15th May. He died peacefully at home.

We are opening a book of condolence for David's many friends and colleagues within the Trust which we will pass to David's family. In due course a memorial event will be held to celebrate his life and huge contribution to health care locally and nationally.

1 ICO Key Issues and Developments Update

Care Quality Commission: Inspection Report
Directors and their teams have completed their factual accuracy checks of the draft report from the CQC following their annual inspection visit in February. (As previously reported, the draft report is strictly embargoed and cannot be shared in public until in its final form and formally published by the CQC). Directors and I met with the CQC on 5 May to discuss initial feedback and priority issues and secured support for a further submission of evidence to provide additional assurance. This is currently being compiled. Following consideration the CQC will then finalise their report and findings which will be published shortly in preparation for a Quality Summit involving key stakeholders being held on 14 June.

ED Recovery Plan
Directors will be aware from the additional weekly board briefings that whilst we have seen sustained performance improvement against some key quality and safety metrics, there is still more to do to sustain all of the improvements we are committed to delivering.

The Board will note from the performance report included in the board pack that overall performance against the 4 hour national emergency care standard has improved in April and is ahead of the improvement trajectory agreed with the CCG and regulators. However there is no room for complacency – demand and pressures so far in May have been challenging and performance has deteriorated which, without an improvement in the remainder of the month, will reduce overall performance against the trajectory. As detailed in the Urgent Care Report in today's Board papers, the Trust has secured SRG approval for a revised trajectory for ED performance (92%) in recognition of the changes to the national Urgent Care Vanguard funding, and pending the development of alternative system wide actions.

Consultant Cover in Maternity

A *Sunday Times* investigation claimed that babies' lives are being put at risk because of variations in maternity units' approach to consultant staffing. At Torbay Hospital, we have consultants timetabled for Labour ward from 0830-1700 hours Monday to Friday. At weekends we have consultant obstetrician presence for approximately three hours each day. However, a consultant obstetrician is available for the full 24 hours on both days, and often will be present for longer than three hours dependent upon clinical need. All our consultants live well within 30 minutes of the hospital and come in if called. As our birth rate is less than 2500, we are not required to have more than 40 hours of consultant cover per week. We do review risk on a continuous basis and may need to expand the consultant base in future. We have board rounds three times a day and a telephone consultation at night.

Carter Review – Ensuring Delivery

Lord Carter's review into unwarranted variation in performance and productivity across the acute sector has implications for the sustainability of the NHS. In total, the Carter Report identified around £5 billion of savings that could be made by 2020. Its 85 recommendations are wide-ranging and challenging. For example, trusts will need to develop separate operational plans for pharmacy, procurement, estates and facilities, data-reporting burdens, and corporate and administration costs (if these were above 7 per cent of their income in 2015/16). These plans are designed to raise efficiency and to save money and will be signed off by NHS Improvement and subject to ongoing central monitoring. Ann Wagner, Director of Strategy and Improvement is leading on this for our Trust as part of strengthening the Trust's approach to performance improvement and accountability, as proposed in the paper considered at the last Finance Committee.

Pressures in Neurology Service

Our neurology service is currently experiencing considerable pressures, with the workforce having reduced from four consultants to two since January. As a result, 350 patients are waiting for their first general neurology outpatient appointment, and 200 patients are awaiting follow-ups. All referrals are triaged by the team, and urgent requests are prioritised. The longest wait for a first appointment is three months, but people referred now who need a routine neurology appointment can expect to wait a minimum of seven months for a first outpatient appointment. We are working with the CCG to stabilise this situation. Measures being put in place include seeking agency and NHS locums, continuing to advertise for substantive consultants, scoping nurse-led service models, and working with neighbouring Trusts to look at the potential for a networked solution and joint appointments. Unfortunately, as they are also experiencing significant pressures in neurology, this is not a swift solution.

Temporary Change to Andrology Services

Due to significant staffing shortages, the Trust has suspended the andrology service for six months. This is to recruit staff, reduce the likelihood of incidents/errors and relieve the stress and pressure on the one member of staff responsible for processing andrology tests. The laboratory will now put in place various procedures and organise training to ensure the andrology service meets the requirements to achieve re-accreditation. GPs have been advised and alternative arrangements are being put in place for post-vasectomy patients and patients within the fertility service.

Voluntary Sector Engagement
An engagement event with voluntary organisations is being planned between the Trust, the Community Development Trust (CDT) in Torbay and Community Voluntary Services (CVS) in South Devon. The date for the event has now been confirmed for the afternoon of Friday 27th of May.

The objective is to use the event to both develop a shared understanding of how the Trust and voluntary organisations should work together and model a new approach to partnership working in the way the event is run. As part of this colleagues from the key voluntary organisations will take a central role in presenting and co-hosting the event. There will be presentations (which will include input from the Trust) and workshops.

We are planning for 60 to 70 participants drawn roughly equally from voluntary organisations in Torbay, organisations in South Devon and the Trust. Key managers from across our acute and community services have been invited along with other colleagues who are leading on projects with voluntary organisations; we have also invited key colleagues from partner agencies.

2 Local Health Economy Update

Wider Devon Sustainability and Transformation Plan (STP) Update
As reported last month the outline submission for the Wider Devon STP was submitted to NHS E by the 15 April deadline. The final full submission is due at the end of June. The Trust's Director of Strategy and Improvement (Ann Wagner) is coordinating the Trust's contribution and representing South Devon and Torbay interests in the planning work.

ICO Consultation on Community Services
The CCG Governing Body agreed at its meeting on 28 April that, subject to NHS England approval, it would progress to public consultation on proposals for the future of community services across Torbay and South Devon. Following that decision, an Assurance Checkpoint meeting took place between members of the CCG, the Trust and NHS England. The CCG and Trust are now working through the final detail of the proposals for NHS England's final approval to commence formal public consultation.

Cornwall's Hospital Requires Improvement
The CQC released its report for Royal Cornwall Hospitals NHS Trust, following an inspection in January. The overall rating was 'requires improvement'. Areas of concern included: not enough stroke patients spending 90% of their time on a stroke ward; a backlog of long waiters for cardiology tests; too few consultants in ED and delays in admission due to pressure on beds as well as patients not being escalated; and staffing challenges in a number of areas. The Trust was praised for its continuing good care at the two smaller hospitals and for the attitude of its staff, whom inspectors found to be caring and dedicated throughout. Chief Inspector, Professor Sir Mike Richards, also commented that the new interim leadership team appeared to be working well together.

Health Education England (HEE) Changes
Professor Ian Cumming, OBE, Chief Executive, Health Education England has written to all CEOs confirming that the HEE National Board has agreed to make changes to the way HEE works with partners and stakeholders to reflect the new Sustainability and Transformation Planning Areas and to ensure that they remain effective and aligned in their local work. The key changes agreed by the HEE Board this week are:

- The creation of four regional local Education and Training Boards, one of which will be in the South.
- The closure of the existing 13 local education training Boards (the local teams and offices in the South West will continue to operate as currently as will the role of the HEE Local Director).
- The dissolution of the current local Chair roles.

These changes will be implemented by 1 August 2016 but prior to that they have a LETB Governing Body meeting on 28 June 2016 when they will be able to discuss and agree local arrangements for the transition, the HEE role in the South West in supporting the STP areas and their future partnership working and engagement.

Public Health Issues:
Tooth decay: According to figures released by NHS England this week, Torbay has the worst rate of tooth decay in the South West for five year olds . In the South West, 21.5% of five-year-olds have tooth decay down from 25% in 2012 and 30.6% in 2008. For Torbay, the figure is 26.8%, whilst Plymouth has the best result in the region at just 15.3%. Nationally, the number of five-year-olds suffering from tooth decay has dropped to its lowest level in almost a decade - less than 25% of the cohort suffers from tooth decay, a 20 per cent drop since 2008.

Alcohol profiles: Public Health England has published local alcohol profiles. The overall position for South Devon and Torbay is shown below. For hospital admissions, Torbay has significantly worse rates than our neighbours in the SW and nationally. Although the rate of increase has been dropping since we have had a hospital-based alcohol liaison team, there is still more work to do to prevent people presenting at hospital in the first place. This is why we are trying to implement a universal screening programme (with variable success) in Torbay.

Indicator	Period	South Devon And Torbay		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.01 - Alcohol-specific mortality	2012 - 14	102	11.5	10.6	11.6	30.6		5.0
4.01 - Alcohol-related mortality	2014	149	44.7	42.6	45.5	81.6		29.1
10.01 - Admission episodes for alcohol-related conditions (Narrow)	2014/15	2,004	683	638	641	1,223		379
9.01 - Admission episodes for alcohol-related conditions (Broad)	2014/15	6,295	2,023	1,977	2,139	3,705		1,270
6.01 - Persons admitted to hospital for alcohol-specific conditions	2014/15	1,240	436	353	364	1,086		158

3 Chief Executive Leadership Visibility

Internal	External
• All Managers Meeting (AMM) • Clinical Medical Group (CMG) • Adult Safeguarding Community Team Visit • Community Hospital League of Friends Chairs Forum • Welcome speech for Internal Clinical Trials Day • WOW awards	**Programmes/Boards/Groups** • Ageing Well Programme Board • Community Services Transformation Group • Children's Improvement Board • Torbay Pharmaceutical's Staff Update Meeting • Voluntary Sector Stakeholder Event • Northern Ireland Expert Panel **Individuals** • Simon Sherbersky, Torbay CDT • Peter Day, Brixham League of Friends • Sue Aggett, Business Lead, Environment Health & Wellbeing Teignbridge Council) • Jennie Stephens, Strategic Director of People, Business Strategy & Support, Devon CC • Caroline Taylor, Director of Adult Services, Torbay Council • Ian Ansell, Torbay Safeguarding Children Board Independent Chair • Alan Denbury, Director of Economic Strategy and Performance, Torbay Development Agency

4 National Developments and Publications

Details of the main national developments and publications since the May Board meeting have been circulated to the Board each week through the new weekly Board developments update briefing which was introduced at the beginning of March.

The Executive Team continues to review the implications of those national developments which particularly affect the ICO and the local health and care system, and will brief the Board and relevant Committees as appropriate.

Specific developments of interest from the past month to highlight for the Board include:

Queens Speech
The second Queen's speech of the current parliament set out the government's programme of social reform including prisons, adoption and the care system. A detailed briefing has been circulated to Board members.

Agreement reached on junior doctors' contract
The British Medical Association Junior Doctors Committee (JDC), NHS Employers and the Secretary of State for Health have reached an agreement on the new junior doctors' contract - subject to a referendum of relevant BMA members. The agreement includes:

- a new approach to pay and reward
- actions to support equality dimensions of the contract
- refinements to previous rota rules
- improvements to flexible pay premia (FPP) and other terms
- clarification of the role of the guardian
- commitments from HEE and GMC.

We are pleased that the contract negotiations have reached an agreed position on which a ballot can be held, and that we are committed to recruiting a Guardian as described for the July deadline. Please see attached press release from ACAS.

Worst A&E performance since targets began
The English NHS has recorded its worst yearly results for four-hour waits in accident and emergency since the target was introduced. Data released by NHS England this month showed 2015-16 performance against the target that 95 per cent of patients should be treated within four hours dropped to 87.9 per cent. A&E attendances increased to 15 million in 2015-16. The total for attendances at type one full A&E units was lower than at any time since 2003-04, when performance was at 88.5 per cent. Attendances have grown by a quarter in that period, from 12m to 15m, while admissions grew by more than half, going from 2.5m to 4.1m. Performance for all types of urgent care providers, including urgent care centres, was 91.9 per cent. The service missed this target for the first time since 2004-05 last year. The number of 12 hour trolley waits fell slightly in 2015-16, from 1,243 the previous year to 1,015. However, this was still the second highest number on record.

The Health Foundation think tank said that considering the financial pressure the NHS was under the performance was good.

Little progress by 'integration pioneers'
An independent evaluation for DH of the initiative said the wider health policy environment had become less supportive of transformation since the pioneers launched. The 14 pioneer sites were launched in November 2013 with a further 11 added in early 2015 and intended to fire the "starting gun" for integration, with pioneer sites demonstrating to the rest of the system how services could be joined up. The evaluation found:

- Limited evidence of change in service delivery except in a few pioneers

- Insufficient support from the centre to tackle some of the systemic barriers to integrated care
- Competing pressures – such as the demands on providers to hit accident and emergency
- The wider health policy environment increasingly unsupportive of whole systems transformation". Finance pressures were potentially undermining efforts to integrate care
- There has been a "narrowing of objectives" compared with the original ambitions stated by the pioneer sites.

Checks on Trust waiting lists

NHS Improvement has launched a £2m project to see how many patients on trust waiting lists for elective procedures are real people needing treatment and how many have been mis-recorded. The project was approved at the regulator's March board meeting and the scheme will see waiting list data validated at 60 trusts. In some cases, trusts with large waiting lists will have failed to remove patients who have been treated, while in others patients have not been included on waiting lists when they should have been. NHS Improvement said the £2m committed to the programme was allocated to trusts on the basis of "how many pathways could be validated, how many could be removed and [an] estimate of its impact on March's RTT based performance". The scale of the validation work is significant compared to the overall cost to the NHS of collecting RTT data – estimated at £3m in 2016/17 – and NHS Improvement said the programme would address recording errors that might incorrectly remove a patient from the waiting list or miscalculate their waiting time.

NHS England reveals breakdown of £22bn efficiencies

According to NHS England figures released this week, more than £6.5bn of the £22bn efficiencies the NHS needs to make by 2021 will come from "national" interventions such as continued pay restraint and cuts to the community pharmacy contract and reducing NHS England central budgets and administration costs. The document, submitted to the Commons health committee, offers the most detailed breakdown to date of how NHS England believes the savings burden will be spread across the health service in the coming years. The new document says the nationally delivered savings leave a further £15bn of efficiencies to be found in local health economies, which includes £8.6bn from NHS provider savings and £1bn from non-NHS provider contracts and reductions in CCG running costs.

NHS drops fines for trusts that miss targets

NHS England has agreed to suspend fines against several indebted trusts that have exceeded waiting times. Over £233m in fines were issued last year for failures to meet targets but as of this month, those foundation trusts and trusts in receipt of bailouts due to forecasted budgetary deficits will not be subjected to sanctions. The remainder, along with private providers, will continue to be fined.

Acas update on junior doctors' dispute

Wednesday 18 May 2016

Following ten days of intensive talks to seek to resolve the long running junior doctors' dispute, an Acas statement setting out the terms of an agreement has been presented to the government and NHS employers, and to the BMA - **Junior doctors' contract agreement 18 May 2016 [235kb]**. This has now been agreed by all parties as resolving the current dispute subject to securing the support of BMA junior doctor members in a referendum.

Work will be done together by both sides over the next two weeks to finalise the communications with BMA members on all the details of the agreement and their new contract. Some elements of the new contract, if approved in the referendum, will be implemented in August this year and all junior doctors will move on to the agreed new terms between October 2016 and August 2017. No further industrial action will be called while the referendum is underway.

The negotiations over the last ten days have been chaired throughout by Acas Chairman Sir Brendan Barber.

Sir Brendan Barber said:

"The negotiators from both sides have worked with great intensity and in a good spirit to achieve this breakthrough. I have particularly appreciated the positive leadership shown by Sir David Dalton and Dr Johann Malawana throughout these talks. I am grateful too that the Secretary of State for Health Jeremy Hunt engaged directly with the negotiations to help move the discussions forward.

"This long running dispute has clearly been an extraordinarily difficult period for the NHS. So I am glad that as well as cooperating closely in preparing the communications for the upcoming referendum, all the parties are also strongly committed to tackling together the bigger, wider challenges facing the NHS.

"Acas has been pleased to have been able to play a part in constructing a positive way forward."

Dr Johann Malawana, BMA junior doctor committee chair, said:

"Following intense but constructive talks, we are pleased to have reached agreement.

"Junior doctors have always wanted to agree a safe and fair contract, one that recognises and values the contribution junior doctors make to the NHS, addresses the recruitment and retention crisis in parts of the NHS and provides the basis for delivering a world-class health service.

"I believe that what has been agreed today delivers on these principles, is a good deal for junior doctors and will ensure that they can continue to deliver high-quality care for patients. This represents the best and final way of resolving the dispute and this is what I will be saying to junior doctors in the weeks leading up to the referendum on the new contract."

Health Secretary Jeremy Hunt said:

"We welcome this significant agreement which delivers important changes to the junior doctors' contract necessary to deliver a safer seven day NHS.

"The talks have been constructive and positive and highlighted many areas outside the contract where further work is necessary to value the vital role of junior doctors and improve the training and support they are given. This deal represents a definitive step forward for patients, for doctors, and for the NHS as a whole."

A copy of the Acas statement agreed between the parties is available **Junior doctors' contract agreement 18 May 2016 [235kb]**. This statement details the issues which were settled during Acas discussions, either outstanding from February discussions or new issues raised during the course of this process. The detailed contract will be available shortly and will include a combination of agreed terms from February negotiations and the new provisions included in this statement.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25 May 2016
Title:	Bay Tree House – Progress
Lead Director:	Liz Davenport
Corporate Objective:	Safe, Quality Care and Best Experience Well Led
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

The Board and Torbay Council's Overview and Scrutiny Committee requested a progress update as further assurance on the availability, suitability and cost of the alternative private sector provision before the decision to close Bay Tree House in June 2016 is implemented. This report details the progress that has been made to date with the 39 current service users and their families/carers. This report was presented to the Overview and Scrutiny Committee on 18th May and the committee agreed to support the recommendation that the unit is closed on 30th June 2016 but in doing so asked that further assurance that the remaining 3 service users have plans in place for short breaks.

Key Issues/Risks

Significant progress has been made in identifying alternative placements for the people who used Bay tree for a short break. This has been made possible through the work completed by the team working with families to agree support plans and the development of a new entrant to the market.

The remaining risks are:

- There are 3 people for whom alternative arrangements have not been agreed
- Families want to feel confident that the time available will allow an appropriate time period for the transition to be made to the new service
- As staff start to secure alternative appointments the ability of the Trust to maintain safe services at Bay Tree beyond 30 June 2016.

Recommendations:

- That the board note the progress with respect to short breaks alternatives for Baytree House service users being put in place and the remaining numbers to be concluded.

- That the board take into account the feedback from the Torbay Council Overview and Scrutiny meeting held on 18th May 2016 that they support the proposed implementation of the closure of Baytree House on 30th June.

- That the board implement the previous recommendation to close Baytree House on 30th June 2016.

Summary of ED Challenge/Discussion:
The Executive Team have reviewed the process of engagement with families and have sought assurance on the appropriateness of the alternative placements. The meeting with families facilitated by health watch was attended by a member of the Executive Team and feedback given to the Board of Directors.

Internal/External Engagement including Public, Patient and Governor Involvement:
The changes have been subject to public consultation prior to a recommendation going to the Board in March 2016, with ongoing engagement with service users, families and carers.

Equality and Diversity Implications:
An Equality Impact Assessment was completed on the proposed care changes

Baytree House short breaks unit for people with Learning Disabilities in Torbay

Torbay and South Devon NHS Foundation Trust Board meeting

Wednesday 25th May 2016

1. Background

Following the Trust Board in early May a further progress report was presented to Torbay Council Overview and Scrutiny meeting on 18th May. This followed on from a meeting that took place on 28th April including family carers, Healthwatch, Councillors and Torbay Council and Trust representatives. At this session it was agreed with council members that a supplementary update would be tabled at OSC on 18th May to provide a revised picture regarding new service for Baytree House service users and families.

2. New Short Break Beds at St Johns, St Marychurch Road, Torquay

Previously much discussion has occurred regarding the new short break beds at St Johns as possible alternative provision to Baytree House. Quite reasonably family carers wished to see the new facility and the beds first hand to enable them to make an informed choice and judgement as to if the accommodation would be the way forward for their loved ones with respect to future short breaks.

At the end of April the work adapting the former St. John's Ambulance building had not been completed in the part of the facility being developed to create a good quality three bedroom short breaks unit. This short breaks unit is designed to provide support to a range of users including people with profound and multiple disabilities (PMLD). This includes people with complex physical and medical conditions who require specialist support. The accommodation also incorporates ceiling tracking, wet rooms and enhanced facilities to support people with complex needs. (Please see attached introductory information) Please note the short breaks unit was dressed/furnished for the open days and additional furniture and artwork is being purchased.

Two **open day events** were held on 12th and 14th May

7 carers/families attended on Thursday 12th and over 18 individual families on Saturday 14th May. Effectively everyone seeking an alternative service to Baytree House attended the open day events or has been to St John's separately during May. Feedback from family carers was positive and time was available to have detailed discussions with the owners and staff at St Johns. Given the above we now have good level of confidence this extra capacity is welcomed by family carers, some of whom have already chosen St Johns and have booked their first short stays and, others have stated that the will book stays taster sessions in the near future.

Week-commencing 23rd May the owners of St Johns and the support planning team are meeting to work through booking arrangements for the next year and then the rest of the family carers who expressed that they would like to use St Johns can look into arranging an initial short stay. As part of this we will agree the logistics of managing emergency short breaks in a flexible fashion.

3. Capacity as St Johns

Previously the Trust explained it had concluded the pricing and contractual aspects of the new service at St Johns in terms of the volumes of bed nights available and a service price categorisation within the facility to meet a range of different service user requirements for a short break.

At the time we expected that the new arrangements will be operational in mid-May 2016. St Johns has now fully trained their existing staff group and is in the process of completing some additional recruitment. The first short-break bookings will now occur in mid-June and six families have already made bookings in first month as at 18th May. Currently our support planning team are working with the provider looking at scheduling bookings and then we can follow up from that. The bookings will increase following the open days and the support planners are actively working with families to plan tea visits as part of the transition process. Currently our support planning team are working with the provider looking at scheduling bookings and then we can follow up from that.

As part of Renaissance and St. John's, the Siesta short breaks unit will be staffed by a team that has received a high level of training. Support staff have been trained in areas such as peg feeding, insulin injections, Makaton/British Sign Language, epilepsy awareness and medication. This enables the team to achieve a high level of care based on individual needs. Staff will also work with staff at Baytree and Hollacombe to ensure that people using the service are fully supported in a person centred manner and that the transition to the new service is well coordinated.

At least Two NHS staff who work at Baytree and Hollacombe respectively have already agreed to undertake some shift work at St Johns. Other Baytree staff have visited St Johns to look at this option although the permanent Baytree staff are currently subject to an NHS redeployment process

Bed availability

3 beds are available for booking; effectively this is extra capacity of up to 1,095 bed nights. The estimate from the support planning team based on assessments and meetings with carers is that approximately 750 beds night per annum may be required. In broad terms approximately two beds of the three available at St Johns would be utilised by these service users. We anticipate that the group of Baytree families effectively will use 2 or these 3 beds in broad terms, subject to scheduling.

Emergency placement

In addition a further 106 beds nights have been blocked booked at St John's for emergency placements provision over and above the like for like replacement of Baytree House usage. Thus this effectively makes a total of 856 night's annual available at St Johns.

Alternative options and developments

To place this in context Baytree beds nights for short breaks in 15/16 was 1,475 nights. The remaining balance of beds nights over and above the anticipated use of St Johns are available via the placements agreed or to follow at Burrow Down, Shared Lives and Braemar.

Additionally since the meeting in April St Johns are bringing a flat with two beds on stream in four to five weeks' time, around 20th June (making 5 short break beds in total). With respect to these extra beds nights they are already 50% booked, however this does leave a further 365 beds night available within the St Johns facility for booking over and above the three new beds (1095) already identified, making 1,460 nights in total from St Johns. In effect these extra 2 beds are available fully on a two weekly cycle on a consecutive basis.

A further 435 beds nights has been secured additionally via the capacity already sourced at Burrow Down and for the people who have chosen Shared Lives. This takes the total nights available to 1,895 beds nights per annum, above the actual levels used at Baytree in 15/16 and 14/15 financial years by approximately 300-400 beds nights per annum for short breaks.

It should also be noted that St Johns has now been rebranded as "Siesta" so it has its own ethos. This also moves the new service away from the previous use of the accommodation to create its own identity.

4. Service user numbers estimate as at Mid-May 2016.

By way of recap, at the end of April our estimate was a follows:

4 Service users	Moved into Support Living or non-Torbay residents
7 Service users in new Short Breaks	Placed with the three different providers
As at 21st April	**Balance of 28 service users for the starting 39**
10 Service users had a definitive option of St Johns but waiting for St Johns to open and visit.	Assuming the 10 cases identified resolve satisfactorily as anticipated this would have left a balance of 18 service users to be successfully found options of 39.
13 families recently visited by Support Planning: Work had commenced on their solutions**.** Waiting for St Johns to open.	At that point if St Johns and other existing providers previously referenced were selected by this group, that would have left a further 5 services users unresolved.
5 Service users to be found remaining placements.	Support planning resources to be deployed exclusively late May and all of June to work on satisfactorily solutions.

Following the successful open days at St Johns we believe the estimate revised position is a follows as at 18th May 2016. From a starting point of 28 service users above seeking alternatives to Baytree, the position as moved forward considerably.

20 service users have chosen St Johns or other specific providers. Arrangements are in hand as outlined in this report to commence initial short breaks.
5 services users are in the processes of making a choice between two different providers, so these individual will have secured provision established in the near future.
3 individual currently do not have a solution in place. We will be working closely with the families concerned in the coming weeks to address this.

5. Market development

The Trust and its commissioners are very aware of the need to expand the short breaks market and to improve and secure the resilience of providers and choice. For many years Baytree has had a lead position in the learning disability short breaks market in Torbay (beds nights 14/15 at Baytree of 1,323 vs. 811 bed nights in the independent sector). In this context the ability to stimulate independent sector investment in this area has arguably not been present. St Johns from example would not have developed their beds for short breaks if the decision to close Baytree had not been made.

Whilst market developments take time, there is a high level of confidence that effective commissioning will yield further choices including for those who are in transition from children's services to adult services as well as wider choice for people in the future. As described within this document we have enhanced capacity in the present but will strive to deliver even more choices in the future. Of course it is true that market changes take time and require engagement with providers to enter with confidence. The Council will in due course be developing a new commissioning strategy in this respect. Providers do require incentives and direction to come forward to expand the capacity and choice to invest in short breaks. To start this conversation Commissioners are holding an "Expo" event in June to work with the market on development in this area. Unfortunately developing additional capacity and choice in a constrained financial climate does take time, but we are working together to improve this situation.

6. Summary

As stated at the March Trust board our intention has been not to close Baytree House fully until alternative plans for short breaks for each of the people who currently use Baytree have been organised. As previously stated this would not occur until the end of June 2016 at the earliest.

However the Trust has commenced its internal NHS staff redeployment process to secure alternative employment for the Baytree staff. We are committed to finding alternative employment for the staff at Baytree and this process is managed in tandem with the changes

for service users and families outlined in this report. During the coming weeks colleagues will work very closely together to ensure the balance of service users and staff leaving Baytree is kept in equilibrium so that the service can be maintained in a satisfactory and safe fashion.

Since the Board decision in March 2016 carers represented by Mr Helmore have requested a further extension of the 30th June closure date to allow more time to secure alternative services and allows for a transition to them. This was articulated at the meeting with carers at the end of April, other forums and in the media.

The Trust is fully committed to ensuring the delivery of high quality services alongside the welfare of staff. With this in mind we are endeavouring to find alternative employment opportunities for our staff through redeployment. The Trust has listened to concerns of family carers about the future of much valued Baytree staff. This does present a realistic need for Baytree to close in the near future due both to finding alternative provision and the need to ensure a safe service at Baytree until the end of June.

Having been briefed with respect to progress with regard to Baytree and following the recent visit of council members to St Johns and Burrow Down, Torbay Council Overview and Scrutiny meeting supported the proposed implementation of the closure of Baytree House on 30th June. The Trust will provide OSC with a regular updates, via e-mail, over the coming weeks as matters move forward, in particular with regard to solutions for the three remaining service users.

7. Recommendation

- That the board note the progress with respect to short breaks alternatives for Baytree House service users being put in place and the remaining numbers to be concluded.

- That the board take into account the feedback from the Torbay Council Overview and Scrutiny meeting held on 18th May 2016 that they support the proposed implementation of the closure of Baytree House on 30th June.

- That the board implement the previous recommendation to close Baytree House on 30th June 2016.

Steve Honeywill
Head of Operational Change
19th May 2016

Siesta

Great care, Great place, Great time

Siesta

St. John's
65 St.Marychurch Road
Torquay
TQ1 3HG

01803 324541

renai@me.com

High quality short breaks in Torbay.

Siesta is our new short breaks service for people with learning disabilities and autism. Our aim to to provide fantastic short breaks that meets the individual needs of people staying here.

Our care at Siesta

There's lots of gadgets to help people. Tracking and hoists in bedrooms.

Hi, my name is Karen. I'm the boss of St. Johns. I am a Learning Disability Nurse and I have been running homes and support for 22 years.

LED light panels to reduce the risk of seizures. Wet rooms and jacuzzi baths.

Hi, my name is Lynne. I'm the manager at St. Johns. We want to give the best possible support and care. All of our staff team are highly trained.

And much, much more!!!

We have lots of experience about supporting people with complex needs. This includes peg feeding, epilepsy, diabetes. This helps us deliver a safe service and adapt to each persons needs.

We have lots of storage so people staying here can have their own duvet, photos and things that are important for them.

Short breaks here will be fun and we will support people to get out and about in our community.

We will work with families to ensure that you are happy with our service now and in the future.

How we built Siesta

Hi, my name is Carl. I'm Karen's husband. I'm also a builder. Right from the start we wanted to create a place that we are really proud of.

Hi, my name is Lewis. I worked with Carl to make the rooms a really good quality.

My name is Andrew. I live at Renaissance. I've helped Carl every day. I'm really proud of our work.

Great Care, Great place, Great time

South Devon Healthcare NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25 May 2016
Title:	St Kilda - recommendation
Lead Director:	Liz Davenport
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:
The reports sets out the outcome of the engagement exercise completed requested by the Board of Directors and sets out the feedback from Torbay Health Overview and Scrutiny Committee.
The report will inform a recommendation to the Director of Social Care on the future of St Kilda.

Key Issues/Risks and Recommendations:
The feedback from the engagement highlighted the following issues:

- Capacity of alternative providers to manage demand
- Quality and ethos of services provided by alternative providers
- Value for money
- Implications for staff

The responses provided to the questions raised enabled the Overview and Scrutiny Committee to support the recommendation not to replace St Kilda and to provide alternatives as part of the new model of care.

Recommendation

- Given feedback from Overview and Scrutiny it is recommended that the Board of Directors reconfirm its previous decision to close St Kilda as outlined in the report of 6th April.

- The Board of Directors recommendations are made in writing to the Director of Adult Social Care Services (DASS) of Torbay Council for a final decision

Summary of ED Challenge/Discussion:

This was reviewed by the Executive Team and support given to progress to engagement with the community in Brixham.

Internal/External Engagement including Public, Patient and Governor Involvement:

Initial discussion with the Director of Adult Social Care and South Devon and Torbay CCG.

Equality and Diversity Implications:
The plan supports intention to ensure equality of access to services across all localities and will be subject to and an Equality Impact assessment

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	25th May 2016
Report From:	Chief Operating Officer
Report Title:	Decision paper: St Kilda Delivery model for community health and social care services for the Brixham community incorporating the re-provision of services currently provided at St Kilda's care home.

1. Background

At the board on 6th April a paper was presented and approved with respect to the St Kilda care facility and its relationship to the delivery model for community health and social care services for the Brixham community. The document covered the history of St Kilda and our rationale for not proceeding with the planned capital new build to replace it. The board also decided that the new care model required a different solutions and thus a decision was also needed in relation to the current contract for services from St Kilda's provided by Sandwell Community Caring Trust (SCCT). Whilst the services at St Kilda are very well regarded and the staff are skilled and compassionate, they do operate in an estate that has a limited remaining life span and not fit for purpose.

The Trust is commissioned by Torbay Council to deliver the services which it sub-contracts to SCCT/St Kilda's. The nature of this proposal makes it a "Key Decision" for Torbay Council under the existing formal partnership agreement. The trust board is required to present a formal recommendation on the model of care, configuration of services and therefore future of the contract with SCCT for the provision of services from St Kilda's to the Director of Adult Social Care Services (DASS) of Torbay Council for a final decision.

It was recommended;

- that the team undertakes more formal engagement with current service users and with stakeholders in Brixham (League of Friends, Brixham Does Care and the Town Council) with respect to these proposals; and
- The output of the engagement will be detailed into a report and a recommendation made to the Director of Adult Social Care at Torbay Council at the earliest opportunity for a final decision.

2. St Kilda engagement

It was agreed that Torbay Council Overview and Scrunity function would take a role in the programme to ensure our approach was appropriate in terms of engagment with key stakeholders.

This report provides details of the engagement that has taken place in respect of the relocation of services from St Kilda and the themes that emerged from those conversations. A good level of engagement occurred at all the meetings. The appendix at the foot of this report contains bullet points of the key themes by each group.

The Brixham Town Council meeting was attended by circa 40 people, the voluntary sector organisations have positively engaged. The Primary Care GP Locality Commissioning Lead for Brixham has been briefed with respect to the proposals regarding St Kilda and is keen to learn the outcome of the engagement process and hear the views of the community. Councillors at both Town and Torbay level have commented and offered input.

A joint engagement meeting occurred with Brixham Does Care and the Brixham Hospital League of Friends. This was a detailed conversation that covered explanations of the Trust's proposals and both organisations responded together. This session was positive and both bodies made an agreement in principle to work closely on and contribute to proposals to develop service activity on hospital site.

Sandwell Community Caring Trust also provided feedback with regard to the proposals. A meeting with staff occurred in April and the CEO from SCCT provided his further comments and concerns.

Throughout the engagement disappointment was expressed as the likelihood of the new build not going ahead. The reasons for this have been well documented in the April board report. Also, recorded in the board report is the fact that there continues to be money spent on on-going maintenance of the building which in itself if not fit for redevelopment to make it fit for future.

Summary of issues

Permanent long stay St Kilda residents – Concern about quality of and capacity in Brixham area independent sector care homes.

Response – Local provision does exist with en-suite rooms etc, with the acknowledgement that further capacity, choice and resilience needs to be enhanced. An existing provider Brixham has recently extended their facility to provide additional quality beds.

Intermediate Care, Step Down and Respite care beds capacity – As above concern about quality compared to the St Kilda ethos and sufficient local choice.

Response- For those clients living in Brixham intermediate care will be delivered locally from the community hospital site which will also accommodate step down clients when required along with other local care homes. The option of block arrangements for intermediate care in existing facilities is also under consideration. Outline discussions with providers have established a willingness and ability to further increase the capacity in this way .The Trust's Business Support and Quality Team provide assurance as to the fact that there is capacity within the homes within the bay. However acknowledgement that the position needs to be improved is important and was raised in the engagement and articulated as a significant concern. Intermediate care at St Kilda is enhanced by NHS staff presently. The complexity of clients is increasing and higher levels of nursing care are required by many. The use of the hospital site potentially improves this situation.

Day care and community meals – More detail and assurance requested with regard to the proposal to move these activities to the Brixham hospital site and work in partnership with the voluntary sector with respect to delivery. Support for working with Brixham voluntary sector organisations.

Response- Space is being allocated on the community hospital site where there is good access. The environment will be in itself suitable having been updated, however this is an interim solution with co-production of a new area/facility being undertaken with the stakeholders (clients, carers, voluntary sector) with the initial investment of £200k capital by the trust. The League of Friends and Brixham Does Care have offered support and partnership and will be working in co-design to develop an enhanced day services offer to the brixham community on site. - Use of the community hospital kitchens will enable the production of the meals presently produced at St Kilda. It is hoped that that the volunteers that run this service will continue to do so picking the meals up from the hospital.

New model of care – This was raised to understand its impact on and connection to the St Kilda change proposals.

Response – At the time of the St Kilda engagement the public was yet to commence but the St Kilda proposals do fit with the proposed changes.

St Kilda estate not being fit for purpose - Detail sought about the practical issues and why the estate cannot be adapted to modern standards.

Response- A range of issues have been identified which include no en-suite facilities, internal fittings not wheelchair friendly, limitations of larger wheelchair access, a single wet room as a few examples. The infrastructure dates from the 1960's and is fundamentally not suited to our aspirations for a modern care environment. Substantial investment would be required which could be better spent on care.

Costs – Assurance sought with regard to economics of the proposed changes.

Response- The block contract arrangement at St Kilda's does not make these beds best value in the market. Although the initial contract with SCCT was for 36 beds, for some time the maximum capacity has been 29 beds and the present use is only 24 beds. With the capacity that exists within Brixham hospital the cost of the beds being used there is already accounted for. This would enable a cost saving for the system and better utilisation of public assets. Some savings are required from these changes.

As one of the larger community assets in Brixham the available capacity in Brixham Hospital is such that there is presently a situation of dual payment where beds being purchased outside of the hospital are effectively an additional cost to the system which would be better spent towards care.

Question with respect to the future employment of St Kilda staff and the transition process if St Kilda closes.

Response- Commitment has been publicly made that staff will be offered opportunities within the NHS to secure new employment and their still retained. SCCT has given nine months' notice on the contract to run services at St Kilda effective from the 1st April 2016. The Trust has a sound record of being able to re-provide services and support clients through changes such as moves brought about during Safeguarding episodes. The protocol for caring for clients and ensuring the support of professional, clinical and care managers will be employed.

3. Overview and Scrunity

Torbay Council Overview and Scrutiny Committee discussed all the above matters in the meeting on 18th May. The debate was passionate and whilst the issues related to the estate are understood members concerns relate to losing the ethos of St Kilda and the compassionate care deliver on site. Secondly they were seeking assurance with respect to securing the same quality, capacity and resilience in the independent sector.

Overview and Scrutiny Board resolved to agree with the conclusion which was outlined in the paper presented to the committee St Kilda report of 18th May.

"As stated the building is such that it is not suitable for redesign or refurbishment in terms of fit for future service provision which means that the present spend on maintenance of St Kilda means that money is being spent on repair not care.

The over-riding question is will people have services that are at least as good or better than they are presently receiving if St Kilda was to close and that in doing so money is being spent on care rather than unnecessarily spent on repairs. The proposals are designed to have people receive services more locally and in establishments that are more modern. It is considered that these proposals are able to meet the concerns raised and enhance the wellbeing of those that require the services provided"

4. Recommendations.

- Given feedback from Overview and Scrutiny it is recommended that the Board of Directors reconfirm its previous decision to close St Kilda as outlined in the report of 6th April.

- The Board of Directors recommendations are made in writing to the Director of Adult Social Care Services (DASS) of Torbay Council for a final decision

Steve Honeywill
20th May 2016

Appendix 1 – Engagement Record

Group/Individual	Date (2016)	Themes/Concerns/Issues
Sandwell Community Caring Trust	01 April	Meeting with Staff at St Kilda
Brixham Town Council	21 April	Resolution: St. Kilda to stay open until a firm and improved solution can be provided The meeting required the 'Improved Solution' to be alternatives to the present St Kilda setting which offered better facilities and opportunities What makes St Kilda not fit for purpose? Will staff be guaranteed jobs? Is there sufficient capacity locally to provide the services presently delivered at St Kilda? Is this allied to the new model of care and community hospital consultation?
Brixham Community Partnership	21 April	Chair in attendance at Town Council meeting Statement re proposals supplied for AGM 19th April
Brixham League of Friends	22 April	These two voluntary sector organisations are working together in a joined up fashion both in terms of responding to the engagement and planning for the future developing change at Brixham Hospital. Considerable disappointment was expressed with regard to the proposal not to proceed with the new build St Kilda 36 bedded unit. Over a number of years the LoF particularly worked with the Trust in partnership to develop the scheme and thus feel the schemes failure particularly acutely. DBD and LoF believe it's important that enhanced services and facilities are provided for health and social care on site at the Hospital to move forward and address the above views and feelings. Broadly the meeting welcomed the proposed transfer of Intermediate Care beds from St Kilda to the Hospital wards and to assure the retention of 20 beds.
Brixham Does Care	22 April	

		There was no objection in principle to the proposals but emphasis was given to the importance of good quality replacement beds, particularly for the four long stay residents. BDC and the LoF have offered their support in working with the NHS in respect of the development of day care services and options for the community of Brixham.
Overview and Scrutiny	27 April	Members concerns related to seeking assurance about capacity and quality in the independent sector for Intermediate Care, respite care and long stay placements, and the loss of what St Kilda provides ethos wide and can the independent sector match this. Members several times naturally connected the St Kilda change to the CCG consultation and model of care proposals. Positive messages about co-design with Brixham Does Care and League of friends. Specifics on staff redeployment and TUPE required by members in finding jobs and retaining skills and mechanism to do so. The NHS and Council need to work hard to bring the Brixham community with them on the St Kilda proposals. . Disappointment new build not proceeding
GPs	May 2016	Requirement to ensure the appropriate medical cover is available for any solution
Sandwell Community Caring Trust / Staff	May 2016	SCCT have been committed to the town of Brixham since and providing quality care and services since 2008 at St Kilda. They are very disappointed that the proposal for the new build will now not proceed. SCCT have committed to working closely and proactively with the NHS both in regard to securing permanent alternative employment for SCCT employee's and the residents of St Kilda and the users of short term bed based care, day services and community meals. SCCT highlight the need to ensure capacity and quality of Intermediate Care and Respite/Step-down short term beds. .

		Likewise that sufficient choice and quality of placement can be found locally for the long stay St Kilda residents so they have a good transition to a new home. SCCT are concerned that moving Intermediate Care beds to Brixham Hospital is not good value and the cost of this service will be higher to the public purse. In general terms SCCT are concerned about the transition period both in terms of how long it may take, finding SCCT staff secure employment given the current change environment in the local NHS and their sense of the capacity of the independent sector.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25 May 2016
Title:	Urgent Care Improvement Plan update
Lead Director:	Liz Davenport
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

To report sets out progress against the Urgent Care Improvement Plan.

Key Issues/Risks

The following issues have been identified in the Urgent Care Improvement Plan risk register

- Data quality – recording of accurate times on symphony
- Ability to cover extended ED Consultant rota
- Royal College of Emergency Medicine guidance on management of ED inpatients limit flexibility to release time to the Emergency Department
- EWS and PEWS data capture
- Capacity in the Information and Performance Team to meet increasing information requirements.
- Effective data capture on sepsis compliance in the Emergency Department

Recommendations:

To **consider the progress and assurances within this** report

Summary of ED Challenge/Discussion:

The Executive Team reviews progress on a weekly basis at the Executive Urgent Care Huddle. In the meetings the challenge has focused on the following areas:

- Workforce capacity and working patterns to support the management of demand 24/7
- Clinical leadership required to implementation of the plan
- Progress against key quality and safety metrics and barriers to delivery of the 60 minute standard for medical review
- The way in which staff use symphony to record practice and the implications of data lag on recorded performance

Internal/External Engagement including Public, Patient and Governor Involvement:

The senior Team meet with the CCG on a weekly basis to report on performance. An update is also provided to the Systems Resilience Group which includes patient representatives.

Equality and Diversity Implications:

.
No impact identified.

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	25 May 2015
Report From:	Chief Operating Officer
Report Title:	Urgent Care Improvement Plan Update

1 Purpose

To provide the Board of Directors with an update on progress in implementing the Urgent Care Improvement Plan

2 Provenance

The report is informed by the following:

- Minutes and reports received at the weekly Urgent Care Improvement and Assurance Group
- Minutes and actions notes from the weekly CCG A&E Oversight Group
- Discussions and actions from the weekly Executive Team huddle monitoring ED performance and compliance with the plan.

3 Background

The Trust agreed a plan to address performance with the 4-hour target and the associate patients safety and quality actions in February 2016. The CCG, NHSE and Monitor endorsed the plan at the meeting of the Systems Resilience Group on 10 February 2016 along with the trajectory that confirmed a planned delivery of compliance in October 2016.

In response to the CQC requirement notice the plan was updated to take account of their observations and recommendations. This revised plan has been approved by the CCG. Internally the Senior Management Business Team, Flow Board the Executive Team and Board of Directors endorsed the full plan. The plan focuses on the areas in which the Trust has direct control recognising that other plans are in place to address wider system issues.

The trajectory has recently been revised with agreement with the CCG to a combined target of 92% by the end of the year. The revised trajectory recognises the impact of the re- prioritisation of the Vanguard programme on to the development of integrated community services and the resulting change in timeline for the funding and implementation of Urgent Care Centres. This revised trajectory will be re-submitted to NHSE and NHSI on 23 May for approval.

An enhanced monitoring structure has been put in place to support implementation of the plan with the intent that this will be transitioned back into the operational governance reporting structures when the plan has been embedded.

- Urgent Care Improvement and Assurance Group – weekly meeting
- Executive huddle - weekly
- CCG weekly monitoring meeting attended by Chief Operating Officer, Chief Nurse and Medical Director.

The Board of Directors receives weekly briefings and progress is formally reported through to the Board as part of routine reporting schedule.

The Board of Directors has identified a non-Executive Director Jacqui Lyttle as a critical friend to the project and she meets with the lead Director Liz Davenport and the Chief Nurse, Jane Viner on a fortnightly basis for a review and challenge session. As part of this work Jacqui spends regular time in the Emergency Department and has agreed to shadow one of the Consultant staff for a day.

4 How the plan was developed

The plan was developed to take account of a number of factors:

- Clinical guidance including advice from the Royal College of Emergency Medicine
- Emergency Care Intensive Support Team (ECIST) diagnostic and advice
- Alamac diagnostic and recommendations
- Vanguard Urgent and Emergency Care route map priorities
- Learning from internal incidents, patient feedback and clinical observations

It should be recognised that there is a growing evidence base from the work of other Trusts that when the standards set out in each area of the plan are implemented that sustained improvement across all measures can be achieved.

The plan will continue to develop as we learn more about how our system could be improved. Some of this learning will be achieved through sharing learning with other organisations. A peer visit has been arranged with the Royal Devon and Exeter Emergency Team and a link has been established with North Bristol NHS Trust.

5 Accountability

Overall accountability for delivery of the plan is with the Chief Operating Officer with the support of the Chief Nurse and Medical Director.

Each work programme has a named Executive Sponsor and a named management lead who is accountable for the delivery of the plan. The leads for the project have an identified support from the Transformation Team and from named members of the

Performance and Information Team. The Transformation Team coordinates the overall programme.

Additional leadership capacity has been identified to support Emergency Care and Medicine. This included having a dedicated senior operational management, senior nurse and medical leadership to the Emergency Department. The named management leads are leading the programme of change.

6 The Plan

The Plan has the following key areas of work:

- Quality- rapid action plan in response to CQC initial findings
- Improving experience
- Acute care pathways redesign including bed reconfiguration
- Implementation of the patient flow bundle
- Review of discharge pathways including implementation of discharge to assess

7 Quality – rapid action plan

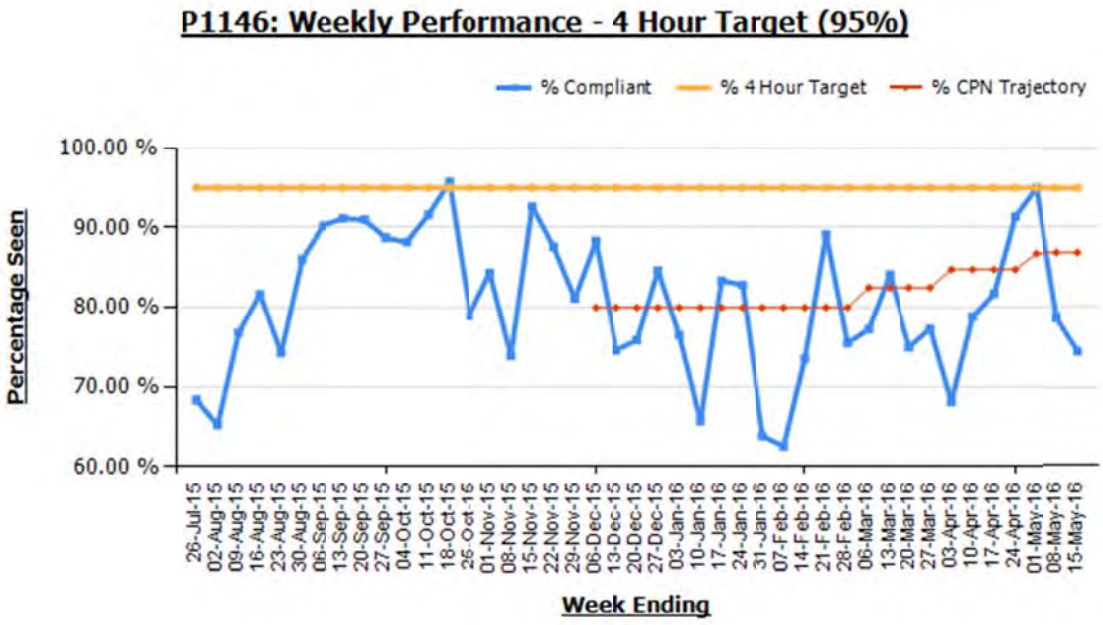
The Plan has been developed in line with best practice guidance and the advice and information from ALAMAC on the factors that impact on effective flow within the emergency department. The core components of the plan include:

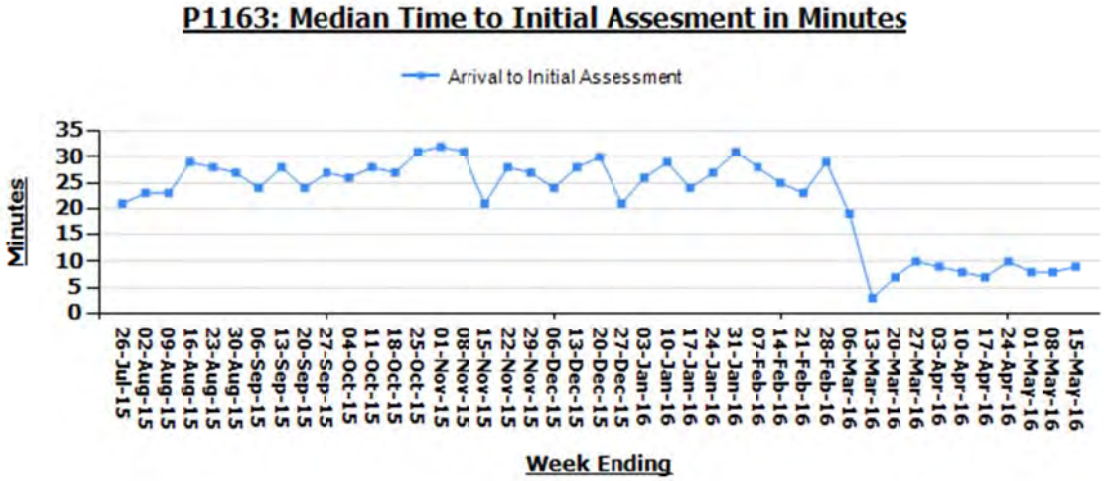
- Improve timeliness to be seen for triage to include time to triage within 15 minutes and first medical review within 60 minutes
- Improve reliability of sepsis screening and antibiotic administration in the emergency department
- Ensure that Paediatric warning score (PEWS)and Early warning scores (EWS) are reliably undertaken recorded and actioned.
- Ensure consistent safe staffing 7 days a week
- Introduce real time monitoring across all bed based care activity accessible and visible from ward to Board to enable pro-active management 7 days a week
- Improve Emergency department governance
- Improve Board visibility of Emergency department performance

The team has focused on this area of work as a priority and progress has been made in all areas with actions completed in line with plan. In the last week the team have been able to demonstrate compliance with the triage standard can be maintained even during busy periods. We have been able to demonstrate improvement to 60 minute standard for first medical review but this is more sensitive to an increased demand in the department given our current workforce numbers.

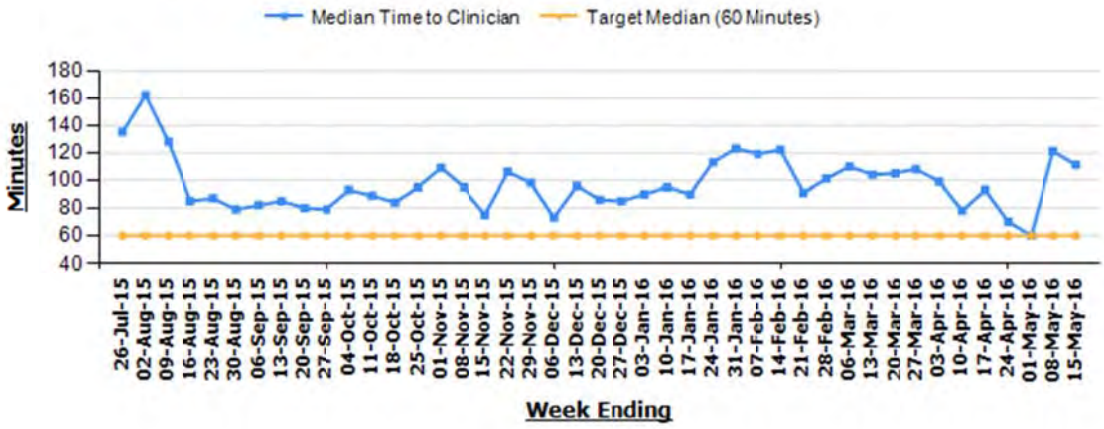
The following tables are a summary of performance against 4 key areas of performance:

1. Compliance with the 4 hour standard
2. Median time to triage
3. Median time to medical review
4. Compliance with sepsis standards

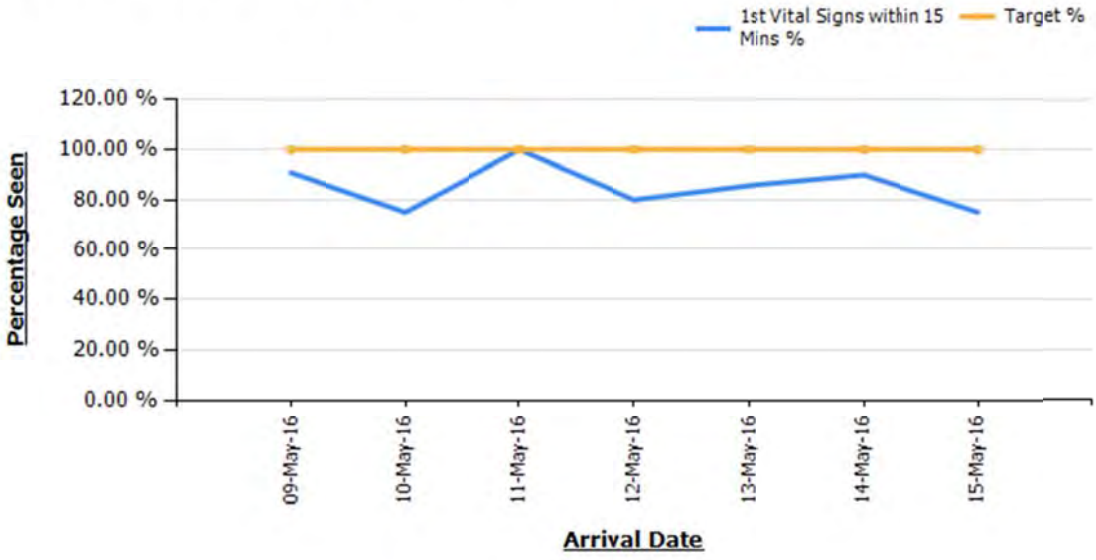


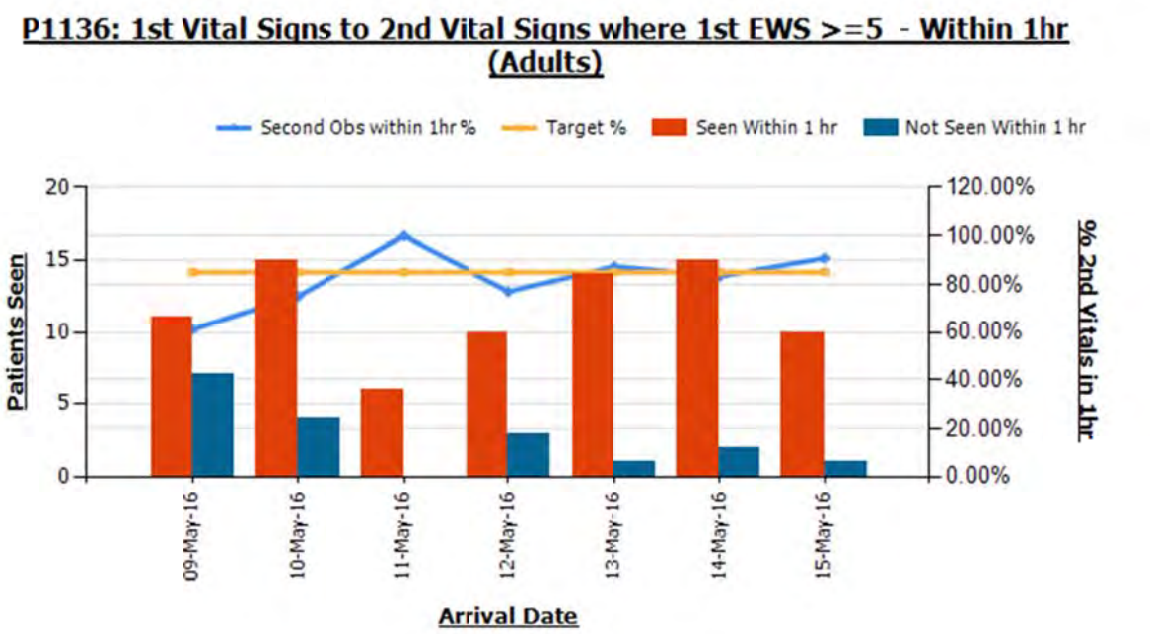


P1150: Median Time to Clinician (Target 60 Minutes)



P1135: Arrival to 1st Vital Signs - Could this be Severe Sepsis = Yes (Adults)





Key points:

- Information is now available on all aspects of ED performance. It is on the computer of all appropriate senior staff and on a screen in the Emergency department and in the control room. This information is refreshed at 15-minute intervals. This information is used to inform the operational response to increased activity at all levels
- The Information Team provides a weekly report detailing performance of the week. This report is presented by the clinical team at the weekly Urgent Care Improvement and Assurance Group. This informs a weekly briefing to the Board and the weekly monitoring meeting with the CCG. The data set in the pack is updated to take account or emerging needs.
- The Board performance dashboard has been amended to include information on the key access standards.
- There has been an improvement in compliance with 15 minute standard with the median performance stabilising at approx. 10 minutes.
- There has been an overall improvement in the first medical review but this continues to be sensitive to fluctuations in activity particularly at weekends and evening when medical staff availability is reduced. A rapid assessment area has been introduced with a named Doctor leading on RAA each day as part of this process.
- The overall improvement in compliance with the sepsis standard has been evidenced but not consistently demonstrated in the data reported on a weekly basis. Audits and patient follows have been completed and they demonstrate the standard has been consistently met in the cases reviewed. There seems to be data recordings delay that impacts on the reported data. This is being addressed through training and improving access to mobile computers that allow data entry at the bedside. A detailed work programme has been

developed in relation to PEWS with audits being completed in the absence of a clinically approved process being available on symphony.

- Training programme on sepsis management rolled out to all clinical staff in ED
- Daily reporting of planned an actual staffing levels are undertaken and submitted to the CCG. The revised staffing levels are consistent with the revised staffing levels highlighted by the CQC
- A 3-day 24/7 review of nursing staffing has been completed in the ED department using the best tool. This assesses nursing staffing needs based on acuity. It demonstrated that staffing was broadly in line with the needs of patients within the department with small-scale changes to capacity required later in the day. The intention is to do a further period of monitoring for 4 days from 19 June 2016. The monitoring process did not include medical staff in detail but it was noted from the initial feedback that that there was a more significant gap in medical staffing requirements at the evening and weekends.
- Discussions have progressed with the Consultant workforce on a change to working patterns. This will include a weekday pattern of 8 am to 10 pm consultant availability to increase to 8 am to 12 pm when the rota is increased to 12 Consultants.
- Internal audit have been commissioned to undertake a review governance arrangements and attend the Urgent Care Improvement Group and Assurance Group.

Risks and issues

- Medical staffing capacity and flexibility to meet the needs during busy periods
- Responsive of specialist consultants to requests for assessments in the emergency department
- Symphony clinical record systems needs to be configured to meet needs of the service and recording practice needs to be changed if the system is to reliably record the actual activity in the department
- Recruitment to enhanced staffing levels need to be made on a substantive basis as there is a reliance on bank and agency staff.
- In the short term there is a need to maintain a high level of audit and patient follows pending the changes to the Symphony system, which is an additional pressure on the staff in the department.
- The escalation response to triggers in the information system is not yet being delivered consistently.

8 Improving experience

A work programme has been introduced in support of improved patients experience. This plan includes:

- Review of complaints and incidents
- Completion of a culture audit
- Safety briefings are held each morning where feedback from yesterday's performance is shared as well as learning from incidents and complaints

- Improvement programmes have been introduced for fall and pressure ulcer management.
- Increased the timeliness of infection control information available to inform operational management.

Key points

- Training programme introduced including enhanced information available to staff on the management of pressure ulcers and falls
- Introduction of Falls and Pressure Ulcer champions
- Pressure Ulcer risk assessment tool introduced and made available on symphony
- Alert timers introduced for people who are on bed pans on trolleys
- Updated falls risk assessment process and standards applied to management of patients at a risk of falling
- Audit of intentional-rounding practice to ensure that practice is completed routinely and actions documented in symphony
- Review of environment to reduce risk of harm
- Cultural audit being utilised team development programme with support of the organisational development team.

Risks and issues

- A review trolley safety has been completed to include utilisation of repose mattresses with potential risk associated with rail height identified. This is being followed up with the provider with the introduction of additional safety measures in the department.

8 Acute care pathway redesign including bed reconfiguration

Three clinical meetings have been held with good clinical engagement across medicine and the emergency department. The meetings have got CCG involvement from one of the lead GPs. An operational management structure is being put in place to include information and transformation team support.

Key points:

- High level mapping of patient flows into the hospital is in progress with volumes of patients identified. This will provide the basis for the work plan and allows baseline data to be captured and an analysis of where the biggest impact of change identified
- Clinicians are leading on the development and implementation of specific clinical pathways focusing on high volume patient presentations; Chest pain, pulmonary embolism, COPD and atrial fibrillation.

The Acute Medical Unit was opened on 21 March 2016. The aim is to reduce crowding in the ED department by allowing direct admission for assessment. There are currently 3 streams with each pathway clearly mapped with clinical exclusion criteria where appropriate for safety. The unit is open Monday to Friday and operates from 08.00 and 21.00 hours The three streams are:

- Direct GP referrals
- Self- presenting patients to ED streamed directly to AMU
- ED patients (already clerked) referred to AMU

Key points:

- Mean attendances per day are approximately 15 patients
- 54% of attenders are discharged home
- A copy of the activity data is attached as appendix 4
- Peak hours of activity are 13.00 and 20.00 hours
- The acute frailty team are based on AMU and there are plans to also relocate the DVT clinic there diverting patients from the Emergency Department.
- Patient feedback is positive
- Staff feedback is positive and there is enthusiasm about the potential to further enhance ambulatory care

Risks and issues

- Currently the unit is not open at the weekend due to medical staffing restrictions
- Sustainability of the workforce as the current model relies on staff working on EAU's providing cover to the unit.
- Timing of attendances later in the day now being addressed where appropriate through the use of PTS to bring patients in earlier in the day.

9 Implementation of the patient flow bundle (SAFER)

The SAFER standard is a tool developed by the Emergency Care Intensive Support Team. The aim of the tool is to increase the number of discharges in the morning, which is believed to have a significant impact on flow. It has been adopted by the NHS as a tool and rolled out across a number of organisations through the Perfect Week initiative. The Trust implemented this programme in June 2015 where an improvement in discharges was identified with a resulting improvement in flow. The programme was not rolled out due to medical staffing constraints.

In the context of the current pressure there has been an across organisational commitment to implement the SAFER standards starting with 4 identified wards in May extended to remaining wards in June 2016. The standards are summarised as:

S- Senior review

A – Anticipate tomorrow's discharges

F – Flow, specialities teams to pull specialities

E - Earlier Discharge

R – React to delays and waits

Key points:

- 4 inpatients units have been identified to include surgery, medicine and community services. The wards are Midgley, Cromie, Ashburton Hospital and Templar ward and Newton Abbott.
- Each team has an identified clinical team leading implementation with dedicated support from the or is it the Horizon Institute
- The SAFER standards have been set out in a driver diagram by the Improvement Team and initial data gathered against each standards
- A driver diagram has been developed for each of the 4 in-patient teams and the local action plan agreed.
- Data is being collated at local level to measure impact
- The Performance Team and ALAMAC at working with units teams to support them in using SWIFT Plus Boards to collect data as part of the routine management of flow

Risks and issues

- Medical staffing job plans and capacity to lead and support the roll out of SAFER
- Clinical activity will need to be re- organised to free up clinical time to wards
- Lack of agreed mandate within clinical teams to support therapy and nurse led discharge
- Pharmacy capacity required supporting Cromie and Midgely two of the four lead units.
- Lack of dedicated discharge lounge facility due to relocation of pre-assessment on Elizabeth Ward.

10 Review of discharge processes

The programme has been developed with the aim of achieving the following:

- Improve timeliness of patients being discharged with complex needs

- To reduce the number of patients medically fit for discharge with a length of stay of more than 7 days
- To extend the discharge to assess model beyond the frailty pathway

A programme of work has been developed with the support of the Improvement Team who have completed a mapping exercise of the discharge process to include, simple, complex, very complex, community hospital and community services discharge.

Key points:

- The Discharge policy has been revised including revised guidance on 'reluctant' discharge.
- Establishing a data set that give baseline information against which improvement will be measured.
- Agreed to focus on the acute part of the pathway which has been identified as having the most significant blocks to discharge
- Full review of the data set to identify options to increase discharge to assess and recruitment of a specialist to help develop a local plan

Risks and issues

- Capacity in the care home sector to support timely discharge
- Discharge coordinator capacity within community hospitals

11 Risk Register

The Urgent Care Improvement and Assurance Group maintain a risk register. The report is reviewed and mitigation plans agreed and incorporated into the plan. The key risks include:

- Data quality – recording of accurate times on symphony
- Ability to cover extended ED Consultant rota
- Royal College of Emergency Medicine guidance on management of ED inpatients limit flexibility to release time to the Emergency Department
- EWS and PEWS data capture
- Capacity in the Information and Performance Team to meet increasing information requirements.
- Effective data capture on sepsis compliance in the Emergency Department

12 Conclusions

The report details progress responding to the quality, safety and performance issues that are created as a result of poor flow through our emergency care pathway. The report provides assurance in relation to actions that are being taken and a summary of the outstanding risks.

The report concludes that although there is an evidenced based programme in place and that programme is being implemented a sustained improvement on performance is yet to be achieved.

Recommendation

To **note** the contents of the report and to discuss if the Board would require further additional actions.

Liz Davenport

Chief Operating Officer

15 May 2016

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25th May 2016
Title:	**Integrated Quality & Performance Report**
Lead Director:	Ann Wagner, Director of Strategy & Improvement
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Purpose:	**Assuranc**e

Summary of Key Issues for Trust Board

Strategic Context:

This month's Integrated Quality and Performance Report, comprising high level summary performance dash board, narrative with exception reports and detailed data book, provides an assessment of the Trusts position for April (month 1) 2016/17 and the 12 month period to the year ended 30th April 2016 for the following:

- key quality metrics;
- regulator compliance framework national performance standards;
- local contractual framework requirements;
- community and social care framework requirements;
- change framework indicators; and
- corporate management framework KPIs.

Areas of under delivery or at risk of not delivering are identified and associated action plans are reported. Due to extended negotiations on the contract with our main commissioner the finance report is not included this month. Full details for months 1 and 2 will be reported in next month's report. The financial position for the 12 months to 31st March 2016 was included in last month's report.

This report is reviewed by the Finance and Performance Committee (24 May) and Executive Director Group (17 May). Contribution and performance of each Service Delivery Unit (SDU) is reviewed by Executive Directors on a bi monthly basis through the Quality and Performance meetings which are now chaired by Ann Wagner, Director of Strategy and Improvement to provide assurance, prioritise areas for improvement, consider support required and oversee action plan delivery. This month the Surgical and Women, Children and Diagnostics Service Delivery Units were reviewed (16 May).

Due to the escalated concern regarding patients experience in and performance of the emergency department, further assurance processes are in place. These include weekly executive led improvement and assurance meetings with commissioner, NED and internal audit attendance; weekly Executive review meetings; weekly Executive to Executive scrutiny meetings with the CCG to provide further assurance; weekly Board briefings with key metrics which are shared with the CCG and Governors and monthly System Resilience Group (SRG) meetings where progress against the urgent care improvement plan is monitored. A detailed update on progress against the Urgent Care Improvement Plan is included in the Chief Operating Officer's report.

Key Issues/Risks:

Quality Framework:

24 indicators in total of which 9 were RAG rated RED for April as follows:

- New pressure ulcers, category 3 & 4 (Acute acquired) – 1 (target 0)
- VTE risk assessment on admission (community) – 92.5% (target 95%)
- Medication errors (Acute) – 30 (target 20)
- Infection control (acute bed closures) – 236 (threshold 100)
- Fractured neck of femur (best practice) – 55% (target 90%)
- Fractured neck of femur (time to theatre) – 69% (target 90%)
- Dementia Find – 44% (target 90%)
- Dementia Assess & Investigate – 44% (target 90%)
- Follow ups past to be seen date – 6082 increasing trajectory

Of the remaining 15 indicators, 11 were rated GREEN, 3 AMBER and 1 TBC

NHS I (Monitor) Compliance Framework:

11 indicators in total of which 2 RAG rated RED as follows:

- Cancer 31 day wait for second/subsequent treatment (Radiotherapy) 93.5% (target 94.5%)
- Urgent care (ED/MIU combined) 4 hour wait– 89% (target 95%)

Of the remaining 9 indicators, 9 were rated GREEN including RTT and 2 AMBER

Contractual Framework:

14 indicators in total of which 9 RAG rated RED as follows:

- Diagnostic tests longer than 6 weeks (acute) – 1.5% (target 1%)
- Care plan summaries % completed within 24 hrs discharge weekdays 64% (target 77%)
- Care plan summaries % completed within 24 hrs discharge weekend 25% (target 60%)
- On the day cancellations for elective operations – 1.47% (target 0.8%)
- Cancelled patients not treated within 28 days of cancellation – 4 (threshold <4)
- Ambulance handovers greater than 30 minutes 102 (target < 75)
- Ambulance handovers greater than 60 minutes 26 (target < 10)
- A&E patients (Type 1 ED only) – 84% (target 95%) – continued improving trend
- 12 hour trolley waits in A&E – 3 (threshold 0) – continued improving trend

Of the remaining 5 indicators, 5 were rated GREEN

Community and Social Care Framework:

11 indicators in total of which 2 RAG rated RED as follows:

- Number of delayed discharges - 351 (threshold 185)
- Timeliness of adult social care assessment – 86% (threshold 75%)

Of the remaining 9 indicators, 3 were rated GREEN and remaining 6 awaiting data or not assigned a RAG rating as performance thresholds to be determined. Of note is the deteriorating position for waiting times for CAMHs referrals with April position 58% seen within 18 weeks.

Change Framework

4 indicators in total – no RAG ratings available pending agreement on tolerances

- Board will note average length of stay and hospital stays in excess of 30 days both increased in April to levels not seen in past year

Corporate Management Framework

4 indicators in total of which 1 RAG rated RED as follows:

- Staff vacancy rate (trust wide) – 7.92% (threshold 4%)

Of the remaining 3 indicators, 2 rated AMBER and 1 GREEN

Recommendation:

1. To **note** the contents of the report and appendices and **seek further assurances** and **action** as required.

Summary of ED Challenge/Discussion:
The Executive Directors Group considered the April position at their meeting on 17 May. In addition to focussing on improving performance against key national standards, Directors reviewed the remaining key quality and performance indicators and agreed future reports need to be structured to bring out key performance trends and utilise measurement for improvement reporting so impact of change can be easily tracked. Ann Wagner, Director of Strategy and Improvement is developing a new style integrated quality and performance improvement report as part of an enhanced quality improvement performance and accountability framework. This will build on the internal audit review recommendations regarding improving performance reporting.

Internal/External Engagement including Public, Patient and Governor Involvement:
Public scrutiny is available through the publishing of this report and the associated data book. Executive briefings to monthly all managers meetings provide a comprehensive update for the Organisation and helps team leaders in setting priorities. Weekly report on Urgent Care issued to all stakeholders.

Equality and Diversity Implications:
N/A

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Board Performance Report

April 2016

1. Summary & Key Issues

1.1 Service and Quality Standards

- **Quality indicators**
  - Capturing Dementia screening information remains a challenge. Improvements are linked to the introduction of Nerve centre planned for June 2016.
  - The number of bed days lost from infection control in April is noted in the report.
  - The number of follow up appointments passed their 'to see by date' has increased and remains a challenge for teams to improve.

- **Monitor Compliance Framework**
  - The 4 hour standard (95%) was not met in April. Overall performance has improved and the local improvement trajectory achieved.
  - The RTT incomplete pathways standard has been achieved target in April ahead of agreed improvement trajectory. There remain challenges in several specialties that are providing increasing cause for concern, these are identified in the report.
  - One cancer standard (subsequent radiotherapy) was not achieved in April. These are provisional figures for April, the forecast remains for all cancer standards to be met in Q1.

- **Contractual Framework**
  - The number of patients waiting longer than 6 weeks for a diagnostic test did not achieve the standard of 1% total waiting. This is in accordance with the trajectory agreed with the CCG.
  - The timeliness of care planning summaries remains a challenge with 64% meeting the 24 hour standard during weekdays and 25% at weekends during April.
  - Cancelled operations remain above target and lost capacity from Strike contingency arrangements has been a factor in April.

- **Community and Social Care framework**
  - No new exceptions are being reported. Safeguarding strategy meetings within 7 days continue to be a challenge along with CAMHS waiting times. A business case for CAMHS is being prepared to confirm the level of additional resources to meet the expected waiting time standards.

1.2 Financial Performance

- The contracting arrangement with our main commissioner is in the final stages of agreement once this is confirmed as agreed a comprehensive income and expenditure position will be provided for month 2

Torbay & South Devon NHS FT Performance Report - April 2016

Performance report

FRAMEWORK
Indicators split by buisness unit
Trustwide / Acute indicators

KEY
(P) = Provisional

	Safest Care	No Delays	Experience	Promoting Health	Improved Value	Target	Red	Amber	Green	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD 16/17
QUALITY FRAMEWORK																						
Safety Thermometer - % New Harm Free - Organisation wide	✓		✓			> 95%	<95%		>=95%						97%	96%	96%	97%	97%	97%	97%	97%
Reported Incidents - Major + Catastrophic - (Acute)	✓		✓			Nil	>=20	Between	<5	2	2	0	0	2	0	3	2	3	1	2	2	2
Reported Incidents - Major + Catastrophic - (Community)	✓		✓			Nil	>=20	Between	<5	1	1	0	1	1	1	0	0	0	0	0	0	0
New Pressure Ulcers - Category 3 + 4 - (Acute acquired)	✓		✓			Nil									2	0	0	3	3	3	1	1
New Pressure Ulcers - Category 3 + 4 - (Community acquired)	✓		✓			Nil									0	0	0	0	1	1	0	0
Never Events - (Acute)	✓		✓			Nil	>=1		<1	0	0	1	0	1	0	0	0	0	0	0	0	0
Never Events - (Community)	✓		✓			Nil	>=1		<1	0	0	0	0	0	0	0	0	0	0	0	0	0
Written Complaints - Number Received - (Acute)	✓	✓	✓			<30	>=30		<30	23	22	18	18	22	22	24	18	23	24	24	18	18
Complaints - Number Received - (Community) - includes written and telephone	✓	✓	✓			<30	>=30		<30	11	17	18	8	11	14	18	14	17	18	10	13	13
(P) - VTE - Risk assessment on admission - (Acute)	✓		✓		✓	>95%	<93%	Between	>95%	94.0%	94.0%	95.2%	95.3%	94.6%	96.2%	96.1%	95.8%	95.6%	95.0%	94.0%	94.5%	94.5%
(P) - VTE - Risk assessment on admission - (Community)	✓		✓		✓	>95%	<93%	Between	>95%	95.8%	98.6%	100.0%	93.4%	97.1%	91.7%	100.0%	100.0%	98.7%	88.8%	90.4%	92.5%	92.5%
Medication errors - (Acute)	✓		✓			<15	>=30	Between	<20	207	28	30	34	36	36	45	39	37	27	30	30	30
Medication errors - (Community)	✓		✓			<15	>=30	Between	<20	32	32	48	35	25	27	21	24	18	32	31	24	24
HSMR - hospital standardised mortality rate	✓		✓			<100%	>=105%	Between	<100%	110%	95%	98%	103%	107%	85%	92%	95%	91%	84%	82%	90%	
Infection Control - Bed Closures - (Acute)	✓		✓			<100	>=170	Between	<100	955	288	40	68	18	54	92	36	12	57	38	236	236
Fracture Neck Of Femur - Best Practice	✓		✓		✓	>90%	<90%		>=90%	74%	50%	59%	62%	61%	64%	71%	76%	80%	81%	70%	55%	55%
Fracture Neck Of Femur - Time to Theatre <36 hours	✓		✓		✓	>90%	<90%		>=90%	87%	58%	66%	76%	72%	86%	87%	67%	89%	81%	81%	69%	69%
(P) - Stroke patients spending 90% of time on a stroke ward - 72hr cohort from Nov-1	✓	✓	✓		✓	>80%	<80%		>=80%	78%	78%	87%	87%	87%	82%	82%	82%	86%	70%	74%	TBC	TBC
CQC Compliance intelligent monitoring score / banding										3	3	3	3	3	3	3	3	3	3	3	3	3
(P) - Dementia - Find - monthly report						>90%	<90%		>=90%	41%	52%	55%	75%	71%	74%	74%	66%	64%	54%	41%	44%	44%
(P) - Dementia - Assess & Investigate - Monthly report						>90%	<90%		>=90%	81%	61%	66%	73%	80%	62%	57%	64%	66%	55%	50%	44%	44%
(P) - Dementia Refer - Monthly report						>90%	<90%		>=90%	100%	100%	100%	100%	100%	96%	100%	93%	100%	96%	100%	100%	100%
Clinic letters timeliness - % specialties within 4 working days							<80%		>80%	73%	86%	77%	73%	59%	59%	73%	77%	73%	77%	86%	86%	86%
Follow ups past to be seen date						Nil				3577	3745	4020	4570	4873	4731	4542	5090	5291	4938	5732	6082	
NHS I (MONITOR) COMPLIANCE FRAMEWORK																						
Referral to treatment - % Incomplete pathways - (Acute)		✓	✓			92%	<92%		>=92%	91.7%	91.4%	92.4%	92.2%	92.1%	91.5%	91.2%	90.8%	91.2%	91.4%	91.8%	92.1%	92.1%
Number of Clostridium Difficile cases - Lapse of care - (Acute)	✓		✓			Nil	>=2		<2	1	3	1	1	2	0	1	0	0	0	0	0	0
(P) - Cancer - Two week wait from referral to date 1st seen		✓	✓			93%	<93%	Between	>93.5%	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.3%	96.3%
(P) - Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		✓	✓			93%	<93%	Between	>93.5%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	97.7%
(P) - Cancer - 31-day wait from decision to treat to first treatment		✓	✓			96%	<96%	Between	>96.5%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.3%	96.3%
(P) - Cancer - 31-day wait for second or subsequent treatment - Drug		✓	✓			98%	<98%	Between	>98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(P) - Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		✓	✓			94%	<94%	Between	>94.5%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.5%	93.5%
(P) - Cancer - 31-day wait for second or subsequent treatment - Surgery		✓	✓			94%	<94%	Between	>94.5%	93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	100.0%
(P) - Cancer - 62-day wait for first treatment - from 2ww referral		✓	✓			85%	<85%	Between	>85.5%	92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	86.1%	86.1%
(P) - Cancer - 62-day wait for first treatment - screening		✓	✓			90%	<90%	Between	>90.5%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%	90.0%
A&E - patients seen within 4 hours (ICO combined A&E figs from Oct 2015)	✓	✓	✓			95%	<95%		>=95%	90%	91%	82%	80%	90%	91%	88%	85%	82%	82%	85%	89%	89%
CONTRACTUAL FRAMEWORK																						
Diagnostic tests longer than the 6 week standard - (Acute)		✓	✓			<1%	>=1%		<1%	2.5%	1.2%	1.1%	2.6%	2.7%	0.4%	0.8%	1.1%	2.8%	1.0%	1.6%	1.5%	1.5%
Mixed sex accomodation breaches of standard - (Acute)		✓	✓			<1	>=1		<1	0	0	0	0	3	1	0	0	0	0	1	0	0
Care Planning Summaries % completed within 24 hours of discharge - Weekday	✓	✓	✓			>77%	<77%		>=77%	55.6%	60.0%	61.0%	61.7%	61.5%	62.4%	61.8%	55.0%	58.5%	58.5%	54.0%	63.6%	63.6%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	✓	✓	✓			>60%	<60%		>=60%	27%	33%	37%	28%	24%	27%	30%	24%	35%	22%	25%	25%	25%

Torbay & South Devon NHS FT Performance Report - April 2016

Performance report

FRAMEWORK
Indicators split by buisness unit
Trustwide / Acute indicators

KEY
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	Safest Care	No Delays	Experience	Promoting Health	Improved Value	Target	Red	Amber	Green	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	YTD 16/17
On the day cancellations for elective operations		✓	✓			<0.8%	>=0.8%		<0.8%	1.31%	1.02%	0.71%	0.84%	0.84%	0.98%	0.96%	1.37%	1.29%	1.42%	0.94%	1.47%	1.47%
Cancelled patients not treated within 28 days of cancellation		✓	✓			<4	>=4		<4	2	4	3	2	0	0	2	3	2	9	10	4	4
Ambulance handover delays > 30 minutes	✓	✓	✓			<50	>=75	Between	<50	27	18	68	87	86	42	103	75	113	234	170	102	102
Ambulance handover delays > 60 minutes	✓	✓	✓			<5	>=10	Between	<5	0	0	1	3	2	2	2	5	2	35	16	26	26
A&E - patients seen within 4 hours DGH only	✓	✓	✓				<95%		>=95%	90%	91%	82%	80%	90%	88%	83%	80%	75%	74%	78%	84%	84%
A&E - patients seen within 4 hours community MIU	✓	✓	✓				<95%		>=95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Trolley waits in A+E > 12 hours from decision to admit		✓	✓			Nil	>=1		<1	0	0	0	0	0	0	3	1	13	10	8	3	3
Number of Clostridium Difficile cases - (Acute)							>=3		<3	4	4	3	2	3	1	2	1	0	1	3	1	1
Number of Clostridium Difficile cases - (Community)							>=1		<1	0	1	1	1	0	0	0	1	1	0	0	0	0
Number of Clostridium Difficile cases - Lapse of care - (Community)							>=1		<1	0	0	1	0	0	0	0	0	0	0	0	0	0
COMMUNITY & SOCIAL CARE FRAMEWORK																						
Number of Delayed Discharges			✓			<185	>185		<185	508	401	320	403	317	211	467	327	325	415	338	351	351
Timeliness of Adult Social Care Assessment			✓			75%	<75%		>75%	71%	71%	71%	70%	70%	70%	71%	67%	69%	69%	69%	86%	86%
Clients receiving Self Directed Care				✓		70%	<70%		>70%	92%	92%	93%	93%	93%	93%	93%	93%	92%	93%	94%	92%	92%
Carers Assessments Completed year to date				✓		>40%				11%	19%	18%	24%	27%	32%	36%	38%	41%	43%	43%	6%	6%
Number of Permanent Care Home Placements			✓			<630				652	652	646	645	639	645	630	636	637	640	635	628	628
Children with a Child Protection Plan				✓		TBC				157	156	161	190	199	216	216	212	174	147	TBC	131	
4 Week Smoking Quitters				✓		>50					126			231			303			TBC	TBC	
% OCU in Effective Drug Treatment				✓		>9.3					7%			6%			6%			TBC	TBC	
% Safeguarding Strategy Meetings within 7 Days				✓		>80%				57%	45%	38%	38%	46%	44%	44%	41%	42%	39%	39%	TBC	TBC
Bed Occupancy										91%	92%	91%	92%	90%	90%	93%	92%	95%	92%	92%	93%	
CAMHS - % of referrals seen within 18 weeks										74%	78%	33%	45%	71%	90%	72%	50%	83%	54%	76%	58%	
CHANGE FRAMEWORK																						
Number of Emergency Admissions - (Acute)			✓		✓	TBC				2546	2631	2732	2580	2694	2776	2760	2708	2609	2740	2945	2797	2797
Average Length of Stay - Emergency Admissions - (Acute)		✓	✓		✓	TBC				3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.53	3.53	3.35	3.41	3.68	3.68
Hospital Stays > 30 Days - (Acute)		✓	✓		✓	TBC				23	33	27	21	28	17	18	21	21	28	29	35	35
LMAT Population Coverage			✓	✓		TBC																
CORPORATE MANAGEMENT FRAMEWORK																						
Staff Vacancy Rate - (Trustwide)						<4%	>6%	Between	<4%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%	6.82%	7.01%	7.92%	7.92%	7.92%
Staff sickness / Absence - (Trustwide) 1 month arrears						<4%	>5%	Between	<4%	4.28%	4.19%	4.16%	4.15%	4.12%	4.07%	4.04%	3.98%	3.99%	4.04%	4.10%	4.10%	4.10%
Appraisal Completeness - (Trustwide)						>90%	<80%	Between	>90%	84.00%	86.00%	86.00%	86.00%	84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%
Mandatory Training Compliance - (Trustwide)						>85%	<80%	Between	>85%	87.00%	87.00%	88.00%	88.00%	87.00%	89.00%	89.00%	90.00%	90.00%	89.00%	88.13%	87.85%	87.85%

3.0 **Summary of Performance dashboard "highlights and Performance variances"**

Overview of Performance as identified in the Performance Dashboard

3.0 Quality Framework indicators

3.1 **CQC regulation compliance assessment**

We received the draft CQC report on April 26th for factual accuracy check. The draft was forwarded to service leads to ensure those who participated in the inspection had the opportunity to inform the final report. The Trust response was submitted by the May 17th deadline and a publication date of May 28th has been set. This is subject to change at CQC discretion. We are planning the Quality Summit to be held June 14th.

3.2 **Fractured neck of femur time to theatre**

The percentage of patient receiving their procedure within 36 hours has fallen in April to 69%, target 90%. There are plans to extend trauma operating capacity that will provide an additional 2 hours per day to increase resilience and improve this performance. These plans are to be confirmed in the 16_17 business planning process.

3.3 **Stroke time spent on a stroke unit part of SSNAP domain 2 – stroke unit key indicator compliance**

The local SSNAP audit data for April is incomplete and KPI performance has not been reported in this months performance report. The deadline for the SSNAP return for April activity is June. The team are working on completing the outstanding audit records. The performance based on the activity recorded in PAS shows a performance of 62.8% for the percentage of patients spending greater than 90% of their hospital stay on the stroke ward (Target 80%).

3.4 **Completion of Dementia find assessment on admission to hospital**

The standard of completing a dementia assessment for all patients admitted to hospital over 75 years old is not being achieved. In April 44% of eligible patients were assessed, the standard is 90%. The introduction of "Nerve Centre" clinical data system will make recording of this data part of the routine electronic data capture and remove the issues of double transcription currently needed which impacts out our reported compliance figures.

3.5 **Care Planning Summary timeliness**

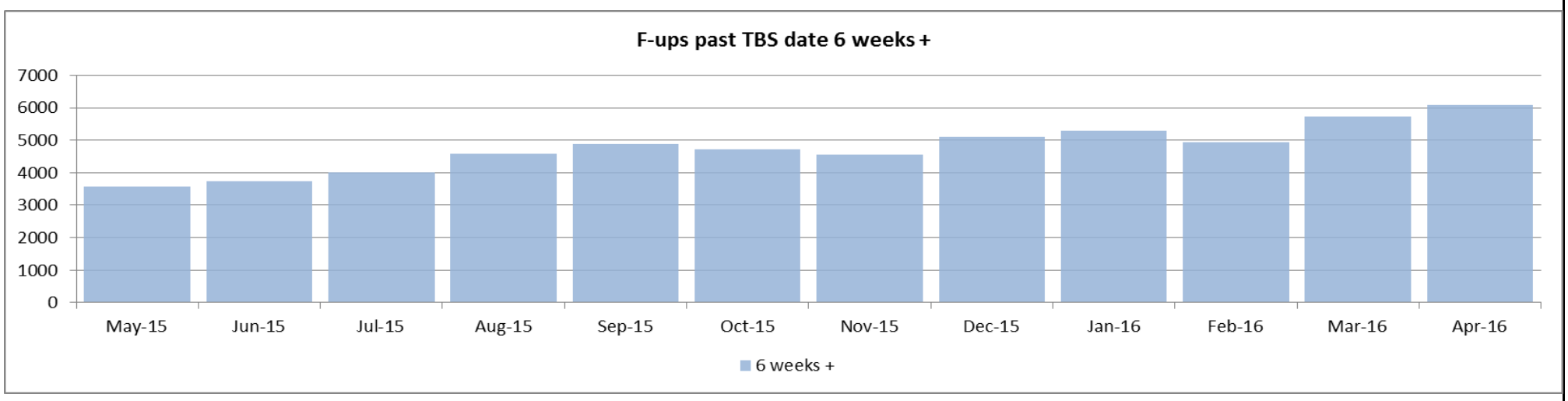
In April the timeliness of care planning summaries improved to 64% sent within 24 hours for weekdays and maintained 25% for weekends. Improving the timeliness of care planning summaries remains a priority.

3.6 **Bed days lost from infection control measures**

For the first time since June 2015 there have been a significant number of bed days lost due to infection control measures – It has been a great achievement from our infection prevention and control and cleaning teams to maintain the low number of bed days lost throughout the winter months.

3.7 **Follow up appointments passed their to be seen by date**

The number of follow up outpatients waiting six or more weeks beyond their 'see by date' continues to increase. The overall number has increased over the year from April 2015 to April 2016 from 3294 to 6082 patients.



The number of patients within each specialty are routinely monitored at the RTT meetings. Service Delivery Units are asked to provide assurance that clinical priority patients are being reviewed and seen if not discharged. The teams are seeking to increase capacity to see these patients and work with primary care and the CCG to agree alternative clinical pathways. Exception reports against the most challenged specialties are attached to this report and shown below.

Number of follow up appointments waiting by time band they have waited beyond intended see by date - April 2016

	0-6 Weeks	6-12 Weeks	12-18 Weeks	18 Weeks +	Grand Total
Cardiology	73	55	64	79	271
Dermatology	213	126	139	73	551
ENT	225	88	73	126	512
Ophthalmology	1672	708	956	950	4286
Orthoptics	347	119	42	0	508
Paediatrics	256	128	115	131	630
Respiratory Medicine	98	81	113	81	373
Rheumatology	348	237	301	411	1297

4.0 NHS I (Monitor) Compliance Framework

4.1 **Annual Plan for 2016/17**

The Annual Plan final trajectories for 2016/17 is due to be submitted to NHS I and will declare risks against following target indicators.

1. A+E 4 hour performance - CCG and SRG agreement to revise previous trajetory to secure 92% compliance against the 95% standard by December 2016.
2. RTT admitted performance – Planned compliance from July 2016

4.2 **April 2016 update against Monitor assurance framework indicators**

4.2.1 **4 hour standard for time spent in A&E**

The standard of 95% was not achieved in April. The ICO performance which combines the Torbay Hospital and the community MIU activity is 89.3% against the target of 95%. Accident and Emergency performance on its own is 84.5% . The community minor injury units achieved 100% against the 4 hour standard.

Summary of A+E performance for April 2016

Arrival /Week Commencing/Month Commencing Date	ICO Attendances	ICO 4 Hour Breaches	ICO 4 Hour Breach % (Target 95%)	ED Attendances	ED 4 Hour Breaches	ED 4 Hour Breach % (Target 95%)	MIU Attendances	MIU 4 Hour Breaches	MIU 4 Hour Breach % (Target 95%)
01-Apr-2016	8,627	919	89.3%	5,924	919	84.5%	2,703	0	100%

The 4 hour action plan shared with the board last month continues to be reviewed weekly by the steering group led by the Chief Operating Officer. To support this oversight and track improvements a detailed weekly performance report has been developed. . The weekly report provides a detailed analysis of clinical pathways, safety indicators and system performance oversight. A summary of most recent progress and issues against action plan monitoring are summarised below:

• Improvements in the 4-hour wait target were seen consistently over the first 6 weeks of the programme, achieving an increase from 75% to 89% of patients being seen within 4-hours. This has put us ahead of the planned trajectory in April.

• In the last two weeks to 15th May there has been a sharp and considerable drop in performance against the 4 hour target, back to pre-improvement levels.

• Time to initial assessment has been improved and consistently maintained over the period, with the implementation of the Rapid Assessment Area and improved SWAST handover process. However, more work is required to achieve the target of 85% seen within 15 minutes.

• Similarly, median time to clinician seen for triage categories 1 to 3 (the most urgent) has experienced an improvement through April against 60 minute target, however in the last fortnight we have seen a drop in performance in line with other metrics. Initial analysis suggests this may be as a result of surges in demand, although doctors have been working flexibly to align job plans to patterns of demand.

• Further analysis is being undertaken to understand causes for the drop in performance experienced, and to identify the actions required to address this. These are multi-factorial and will require collaborative working with partners across the system.

Issues and Obstacles

• Considerable pressure across the system as a whole in first two weeks of May, with NHS 111 and GP out of hours services experiencing similar issues in terms of maintaining performance in the context of increased demand. Demand is particularly high during the out-of-hours and weekend period, which results in considerable backlogs in the system early in the week.

• Crowding in the department as a result of "bunching" of arrivals –particularly GP direct referred patients conveyed by SWAST. Challenging to manage such surges in demand within the capacity of the department and medical resource available. BEST analysis has been undertaken alongside a newly developed hourly crowding report. These will support the alignment of workforce to demand patterns; as well as assisting in in-depth analysis of the underlying causes for crowding, so that we may take steps to address them.

• Issues regarding flow and bed availability at times of peak demand have had a significant impact on the number of breaches in the department. The implementation of SAFER seeks to address this in part, and this is already underway at 4 sites across acute and community. However additional work with primary care and SWAST is essential to address the flow through the wider system which impacts upon the department.

• Continued reliance on bank and agency puts additional pressure on substantive staff to support, particularly around the recording of information and reporting/escalation processes. However, additional nurses have been recruited substantively to the department, which should go some way to mitigating this issue once they are in post.

• Considerable efforts have been made by both operational and performance teams to improve the quality and robustness of recording, to ensure that data is a true reflection of the performance in the department and can be used effectively to highlight/ address underlying issues. However, there remain issues in some areas which are being addressed by education/training of staff and an update of Symphony to improve functionality.

4.2.2 **RTT incomplete pathways**

The standard of 92% has been achieved in April. The table below shows the reported performance level of 92.14 % and analysis of all specialties not achieving the standard.

	<126		>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Urology	163	607	59	16	845	91.12
Ophthalmology	599	947	161	22	1729	89.42
Plastic Surgery	117	40	16	5	178	88.20
Trauma & Orthopaedics	613	928	169	73	1783	86.43
Pain Management	187	277	59	21	544	85.29
Restorative Dentistry		30		6	36	83.33
Colorectal Surgery	89	310	38	52	489	81.60
Clinical Neuro-Physiology		25		7	32	78.13
Upper Gastrointestinal Surgery	105	242	112	18	477	72.75
Grand Total	3128	11643	700	560	16031	92.14

At individual specialty level improvement in Ophthalmology has continued with the backlog position being 149 ahead of trajectory. This is the main factor for achievement against overall target in April.

There remains however, a number of specialties who's performance is currently deteriorating and could undermine the positive impact of Ophthalmology in coming months and these are summarised below:

• Neurology – Loss of consultant capacity - Discussions with neighbouring trusts to create arrangements for partnership working and increased on site capacity are on-going. It is unlikely that any permanent arrangements will be in place before Sept 16 so an increasing backlog in this period is being predicted. Other short term arrangement are also being explored.

• Pain Management – Loss of locum and not being able to recruit to vacant post has impacted on capacity and backlog of patients awaiting treatment is increasing. A local In house solution to change work plans is being agreed that once implemented can replace the lost capacity.

• Urology – The phasing of consultant retiring (July 2016) and full time replacement consultant starting (September 2016) will see an increase in backlog over Q2.

• Gastroenterology – Current shortfall in capacity will continue until new consultant starts in Sept 16. Clinical team are supporting additional clinics but this remain below that required to reduce current backlog.

• T&O – Winter pressure has seen high numbers of elective cancellations with outsourcing now required to support the reduction in numbers waiting over 18 weeks. Recent reduction in referrals for hip and knee outpatients following introduction of physio led screening is encouraging, however the numbers being added to the operating list have remain unchanged.

• Colorectal and Upper GI – Numbers of routine patients waiting for treatment remains above plan with the clinical focus being of the more urgent pathways and loss of elective capacity from winter pressures on beds. The business case for additional consultant recruitment to support both the emergency and elective capacity to achieve RTT trajectory remains to be approved.

All RTT delivery plans are reviewed at the biweekly RTT and diagnostics assurance meeting chaired by the chief operating officer (COO) with the CCG commissioning lead in attendance.

4.2.3 **Clostridium Difficile (c-diff)**

The 2016/17 National objective for the number of C.diff cases is 18 cases. For Monitor compliance reporting the target in 16_17 is 18 cases measured as the number of cases agreed with commissioners being due to a "lapse in care". In April, there are no new cases of c.diff identified as a lapse in care.
The dashboard details the number of cases and the split between community and acute settings.

4.2.4 **Cancer standards**

In the provisional data, one cancer target, 31 days for subsequent radiotherapy, is being identified as not being achieved in April. This is prior to final validation and submission in national returns due in early June and these provisional figures are likely to improve.

Provisional April performance

	Target	No. Seen	Breached	%
14day 2ww ref	93.0%	0	0	100.0%
14day Br Symp	93.0%	0	0	100.0%
31day 1st trt	96.0%	189	7	96.3%
31day sub drug	98.0%	66	0	100.0%
31day sub Rads	94.0%	46	3	93.5%
31day sub Surg	94.0%	30	0	100.0%
62day 2ww ref	85.0%	103	13.5	86.9%
62day Screening	90.0%	20	2	90.0%

The final return of March and Q4 confirmed that all targets had been met.

5.0 **Contract Framework**

The local CCG contract for 2016/17 is in the final stages of being agreed, heads of terms for the contract have been shared and it is anticipated that it will be possible to report positively on the agreement by the time of the meeting.

Service Transformation Fund performance trajectories. There trajectories are being agreed with the CCG will be submitted on 23rd May for the following performance standards.
- RTT % patients waiting under 18 weeks (Target 92%) - Planned delivery July 2016
- A+E / MIU (type 1 and 2) waiting times < 4 hours (Target 95%) - Planned trajectory of improvement to achieve 92% by August 2016
- Cancer 62 day referral to treatment (Target 85%) - Target delivered from April 2016.
- Diagnostic waiting times < 6 weeks (Target 99%) - Planned delivery July 2016

5.1 **Commissioning for Quality and Innovation (CQUIN)**

The CQUIN assessment for 2015_16 Q4 schemes have been submitted and feedback awaited. CQUIN schemes for 16_17 are not confirmed and will be agreed by the contract long stop date on end of June. In 16_17 the CQUIN again will comprise of nationally mandated schemes and some locally determined. CQUIN value will represent 2.5% of overall contract value for locally commissioned and 2% for specialised commissioned services.

5.3 **Diagnostic tests waiting over 6 weeks**

The standard to see 99% of all patients within 6 weeks of referral was not achieved in April. There remain capacity pressures particularly in CT (30 patients > 6 weeks) , MRI (5 patients > 6 weeks) and Audiology (13 patients > 6 weeks) . The total number of patients recorded as waiting for diagnostic tests over the 6 week standard at the month end census is 54 giving a performance of 98.54% (Target 99%). This performance is in line with the submitted Trajectory for monitoring against the Service Transformation Fund (STF).

In Radiology recruitment to vacant radiologist posts and maternity cover remains the current challenge . Immediate plans for increasing capacity include outsourcing for scan reporting, to release radiologist time, mobile CT capacity at Mount Stuart hospital and to continue with additional contracted sonographer sessions.

CT scanning at weekend has now been increased from one scanner to having both scanners operating on both Saturday and Sunday 9am - 5pm. Increased staff training to fill the additional CT sessions has however been a factor in recent weeks and this has had an impact on overall routine capacity.

5.4 **12 hour Trolley wait in A+E**

In April, three patients waited over 12 hours in the emergency department from decision to admit to admission to a ward bed. The long waiting times for admission to a ward bed were all managed as part of the wider system escalation and in the best interests of overall patient safety. The remedial action plan for the 4 hour standard covers the actions needed to prevent these long waits for admission and is being monitored as part of the overall plan. All 12 hour trolley waits have been validated prior to reporting and shared with commissioners for exception reporting.

5.5 **Cancelled operations**

In April, the number of elective operations cancelled on the day by the hospital of admission exceeded the national standard of 0.8% with 1.47% (47 patients) of patients cancelled on the day of surgery. The cancellation reason is summarised as follows:

- Emergency / priority - 16 cancelled operations
- No ITU / HDU Bed - 10 cancelled operations
- list overrun - 8 cancelled operations
- Equipment / facilities - 7 cancelled operations

In April, elective capacity was reduced by an estimated 157 cases over the period of the Junior doctor strikes to increase emergency bed capacity and release clinicians for emergency cover. In addition to this a further 49 patients were cancelled by the hospital and 23 by patients on the day before admission . Reasons for cancellations the day before admission can be varied however it is recognised that these cancellations are likely to reflect poor patients experience and lost capacity.

Four patients previously cancelled on the day of surgery were not readmitted within 28 days in April.

6.0 **Community and Social Care Framework**

The Community Quality and performance dashboards have been reviewed. The Adult safeguarding standard has been escalated as a priority risk and the CAMH service continues to have long waits for initial assessment and treatment. A business care to increase CAMHS staffing levels has been submitted.

7.0 **Attached to this report**

Exception templates - Specialty level exceptions templates for follow up appointments over 6 weeks and Stroke KPI for stroke unit access are included in this report

Appendix 1 - Performance M01 databook

Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	Follow up appointments beyond to be see by dates	M1 - exception template

Data Analysis

Monthly performance summary **Ophthalmology**

Commentary

The Ophthalmology department manage many patients with long term conditions that require repeated follow-up appointments within strict timescales to manage clinical risk. These higher risk patients are the main priority for managing patients to within 6 week of their planned see by dates and as a result, patients with lower clinical risk can wait longer for their appointment.

a) Trend over last 12 months see graph opposite - The trend in the last 12 months is upwards and this will continue until the necessary space is allocated to the service. Many improvements have been made over the past years to cope with increased demand and provide increased capacity (Macular Mega clinic and Nurse led services). The requested new rooms are coming on line in June 2016, the equipment required to utilise these is still waiting for approval to order. Additional resource will be required to achieve a sustainable position with expected year on year growth in follow up demand.

b) Analysis of case mix - The case mix is wide but is focused around Macular, Glaucoma & Medical Retina account for 80%. The remaining are Diabetic, Uveitus, Paediatric, Corneal, Oculoplastics, Cataracts and General.

c) Managing Clinical Risk - Each clinic and pending list is allocated to a responsible consultant. The highest risk patients are tracked and seen as a priority (Macular - all under 6 weeks)

d) Actions being taken - The additional rooms and kit are required to see these patients. We have already provided for the staffing with AHP's and new ways of working but lack the space to fully utilise these. Due to the expense of the diagnostic equipment, these clinics need to be cohorted. Greatest risk is in patients waiting 0-6 weeks i.e. Macular

e) Forecast for September 2016 - Provided the rooms and equipment are available for June 2016, performance should stabilise by September 2016. Improvement should be seen by December 2016 once the high risk Macular patient do not wait past their to be seen by date.

Improvement Plan

No.	Action	Lead	Date
1	Additional Clinic rooms - Estates	John Steer	
2	Extra Equipment for rooms - Capital	Mark Stewart / Joe Seah	
3	Clear Level 1 to allow for more expansion	Derren Westacott	
4			

Governance Arrangements

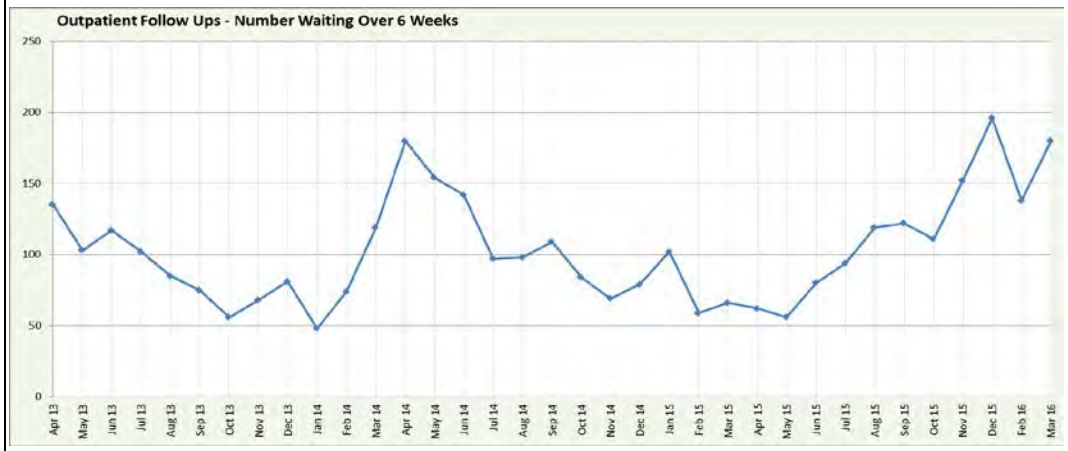
Patients waiting are reviewed at Directorate meetings and at sub specialty meetings, particularly Macular. Consultant lead responsible for each sub-specialty.

Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	Follow up appointments beyond to be see by dates	M1 - exception template

Data Analysis

Monthly performance summary **Orthoptics**



Commentary

Orthoptics are intrinsically linked to the Ophthalmology department providing for their own capacity and that of Ophthalmology as AHP's.

a) Trend over last 12 months see graph opposite - The Orthoptic department support the Ophthalmology department and work across both specialties. The higher risk patients are seen as a priority and these are mostly within the Ophthalmology department causing delays to the Orthoptic patients.

b) Analysis of case mix - Case mix over Paediatrics, special needs children, contact lens and as AHP's for Eyes

c) Managing Clinical Risk - Orthoptist lead responsible for the pending list and reviewed regularly. Due to school restrictions for children screening, the pending list can increase significantly until the next school visit.

d) Actions being taken - Additional space required for the service but priority being given to ophthalmology as it carries a higher risk.

e) Forecast for September 2016 - There is unlikely to be any improvement to this position until the higher risk Ophthalmology patients are seen at their specified date.

Improvement Plan

No.	Action	Lead	Date
1	Continue to review the position and risk	Jane Woods	
2			
3			
4			

Governance Arrangements

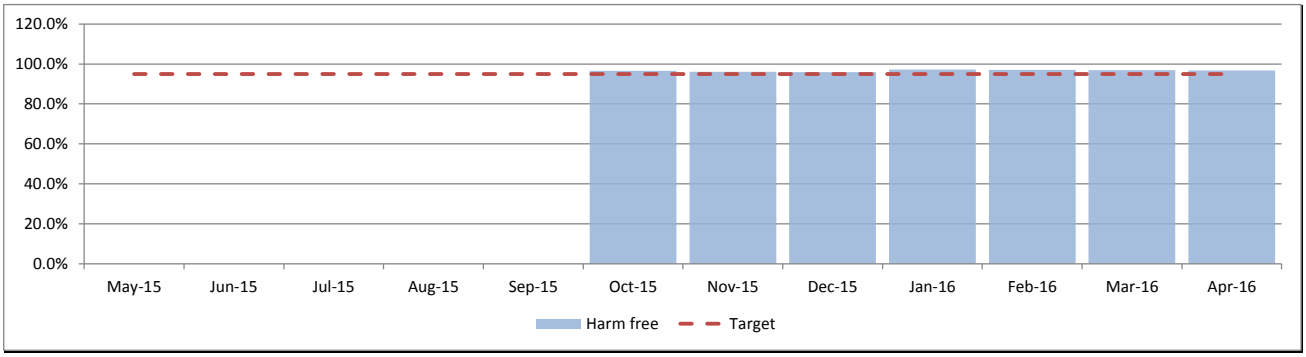
Patients pending list reviewed by the lead Orthoptist - Jane Woods

Performance & Quality Databook

Month 1 April 2016

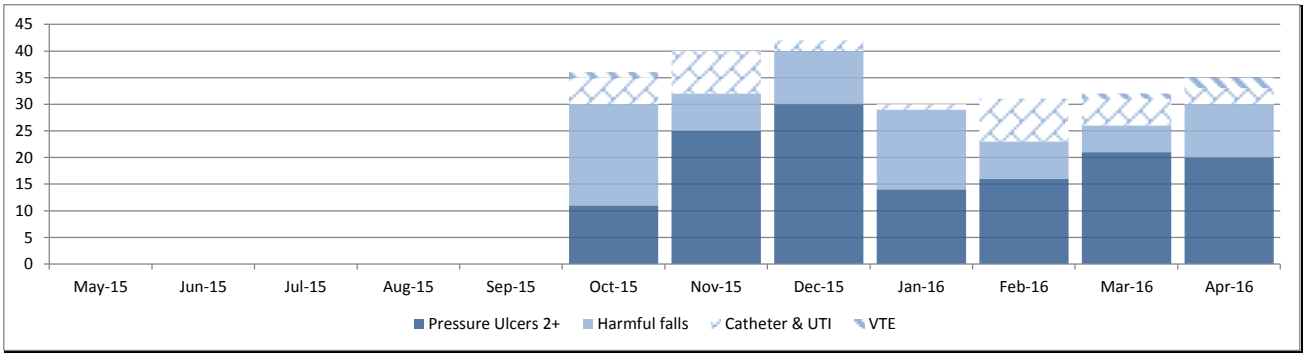
Harm Free - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients						985	1044	994	1109	1075	1057	1027
Harm free						951	1003	953	1079	1044	1025	994
Harm free						96.5%	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



Types of new harm - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
New Harms						34	41	41	30	31	32	33
Pressure Ulcers 2+						11	25	30	14	16	21	20
Harmful falls						19	7	10	15	7	5	10
Catheter & UTI						5	8	2	1	8	5	3
VTE						1	0	0	0	0	1	2



This is a combined report on Safety Thermometer

Overview of Organisational ST Safety Work

• The Pressure Ulcer Project is now well established across all care sectors, which will utilise a buddy ward system to aid the learning and sharing from prior wards that have participated in the programme.

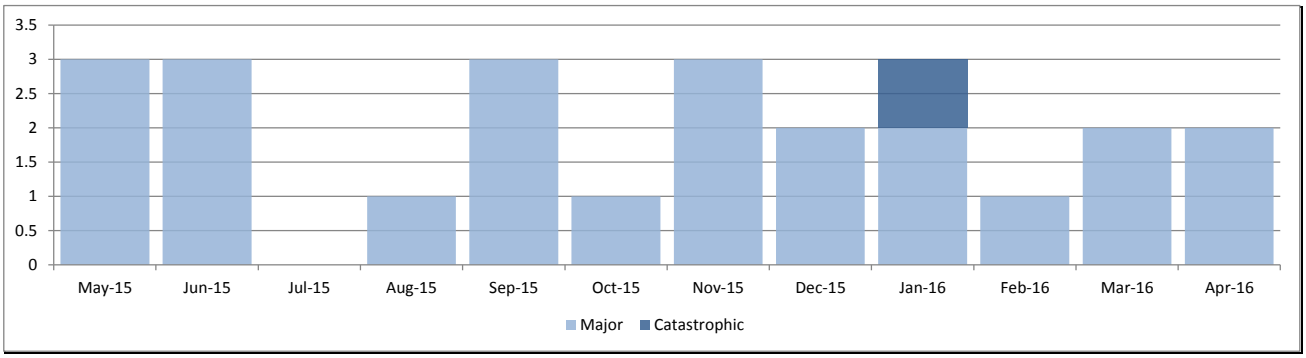
• SWARM continues to be used should a serious pressure ulcer develop. This involves a meeting of the ward manager, matron, TVN as soon after the event as possible to gather information as to why the event occurred.

• All VTE events are investigated and the structure and people are now fully in place for this to happen. Feedback following the RCA is given to the clinicians.

• The Falls team are reviewing process and policy in terms of Hi Lo beds and merging the Communities and Hospitals policies into one document with a view to simplifying documentation. All falls are looked into and any trends and patterns are shared with the wards and falls committee for further sharing and learning.

Incidents recorded on Safeguard

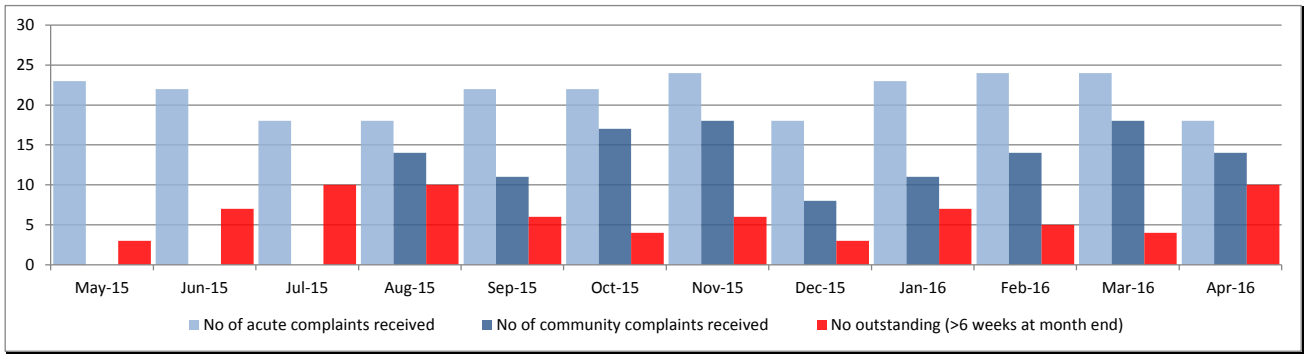
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Near miss	104	66	85	58	67	58	55	61	71	59	62	59
Near miss - major	15	7	4	5	5	5	6	11	4	3	3	7
No harm	352	205	204	223	210	232	250	201	192	184	195	104
Insignificant	42	43	30	45	43	37	27	43	34	36	34	27
Minor	163	140	131	148	118	140	123	127	115	106	103	77
Moderate	23	19	26	28	24	26	25	26	31	28	7	13
Major	3	3	0	1	3	1	3	2	2	1	2	2
Catastrophic	0	0	0	0	0	0	0	0	1	0	0	0
(blank)	0	0	0	0	0	0	0	0	0	0	0	0
Total	702	483	480	508	470	499	489	471	449	417	406	289



Incident reporting remains consistent. An ICO view of incident data combining safeguard and Datex reporting systems is being developed and will be incorporated in the next report.

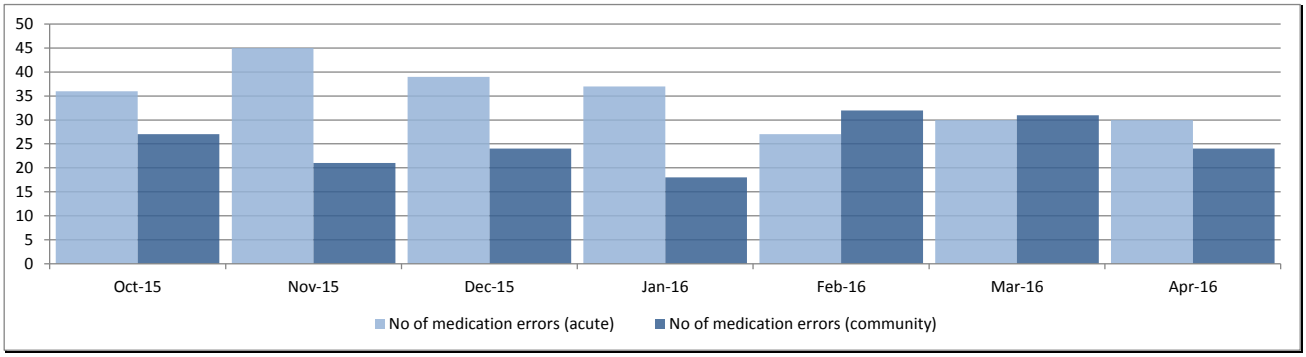
Written complaints - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
No of acute complaints received	23	22	18	18	22	22	24	18	23	24	24	18
No of community complaints received				14	11	17	18	8	11	14	18	14
No outstanding (>6 weeks at month end)	3	7	10	10	6	4	6	3	7	5	4	10



Medication errors - Trust Total

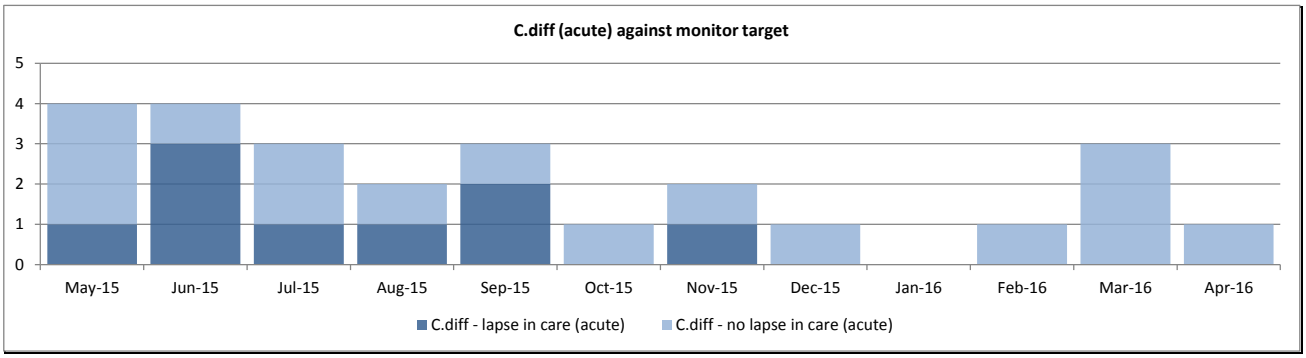
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
No of medication errors (acute)	207	28	30	34	36	36	45	39	37	27	30	30
No of medication errors (community)	32	32	48	35	25	27	21	24	18	32	31	24



Now including community data. In March, the acute recorded a significant reduction, and will need to be observed over time.

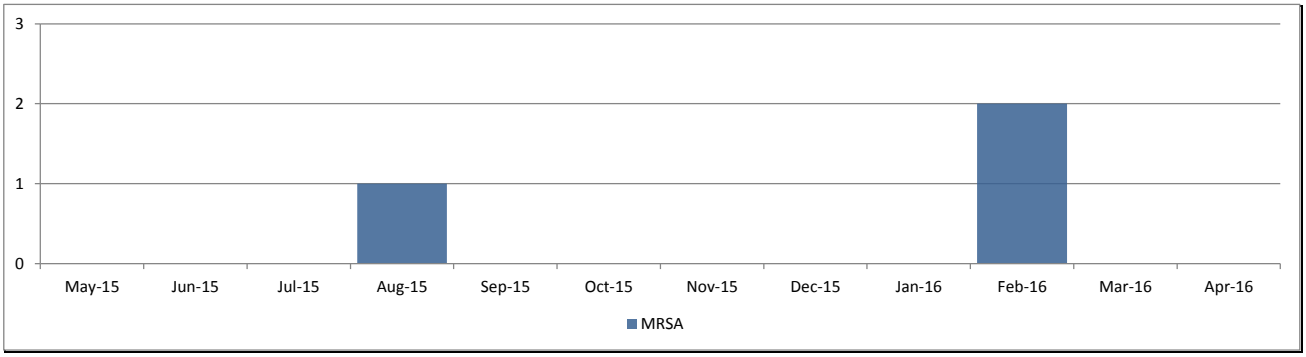
Clostridium difficile

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
C.diff - lapse in care (acute)	1	3	1	1	2	0	1	0	0	0	0	0
C.diff - no lapse in care (acute)	3	1	2	1	1	1	1	1	0	1	3	1
C.diff - Total (acute)	4	4	3	2	3	1	2	1	0	1	3	1
C.diff - lapse in care (community)	0	0	1	0	0	0	0	0	0	0	0	0
C.diff - no lapse in care (community)	0	1	0	1	0	0	0	1	1	0	0	0
C.diff - Total (community)	0	1	1	1	0	0	0	1	1	0	0	0



Methicillin-resistant Staphylococcus aureus (MRSA) - (acute)

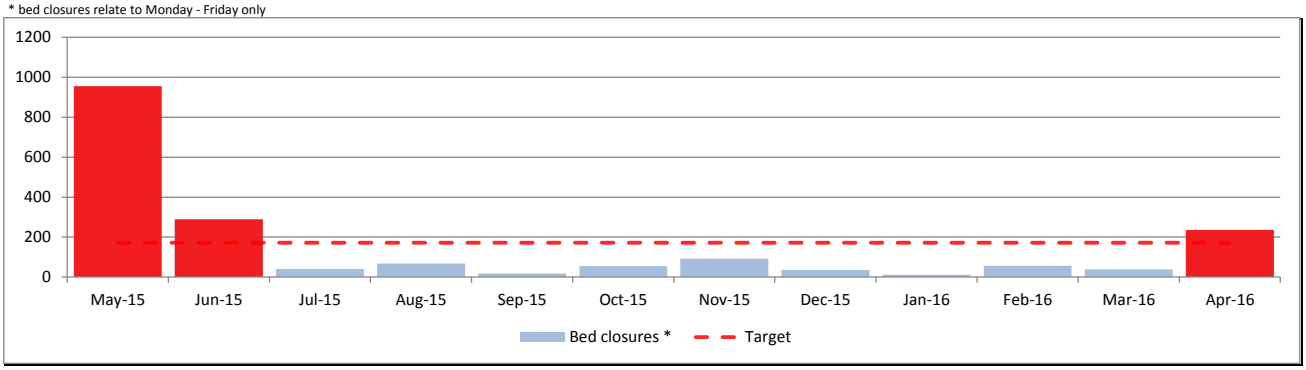
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
MRSA	0	0	0	1	0	0	0	0	0	2	0	0



Bed closures due to infection control measures - (Acute)

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Bed closures *	955	288	40	68	18	54	92	36	12	57	38	236
Target	171	171	171	171	171	171	171	171	171	171	171	171

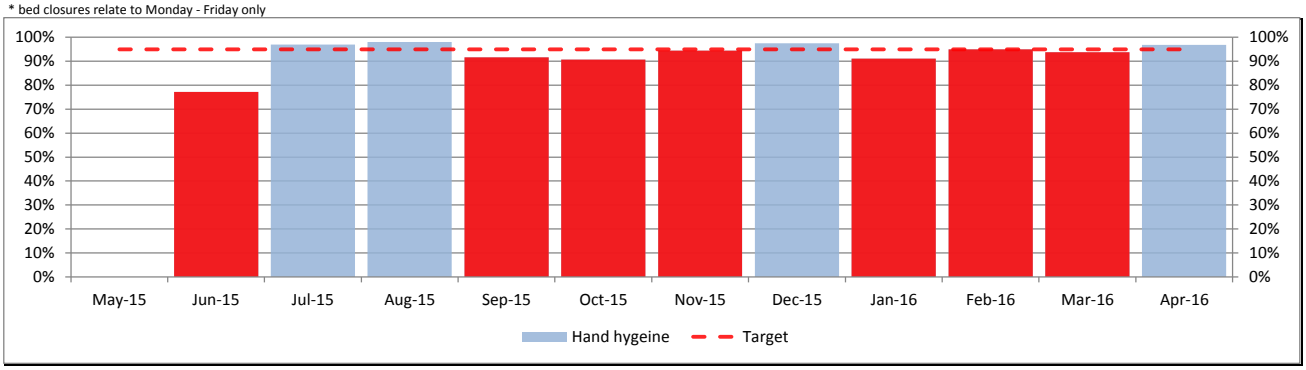
* bed closures relate to Monday - Friday only



Hand Hygiene - (Acute)

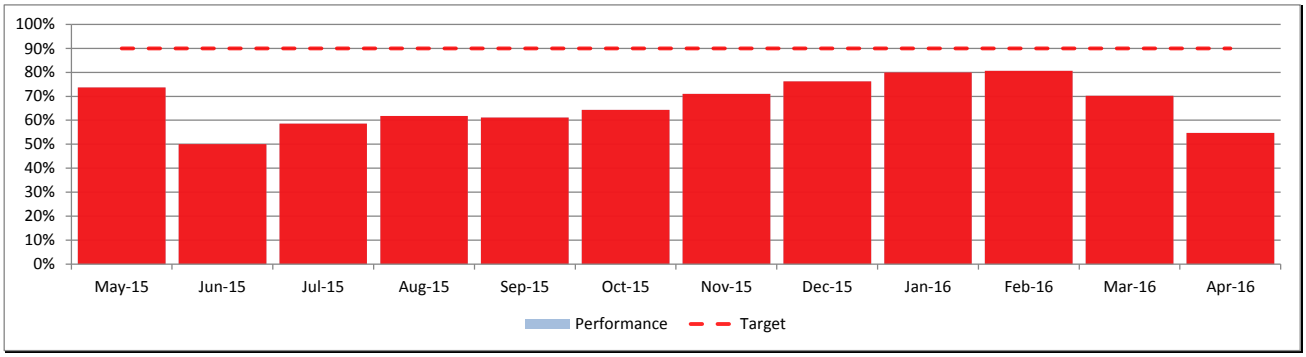
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Hand hygeine	n/a	77%	97%	98%	92%	91%	94%	97%	91%	95%	94%	97%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* bed closures relate to Monday - Friday only



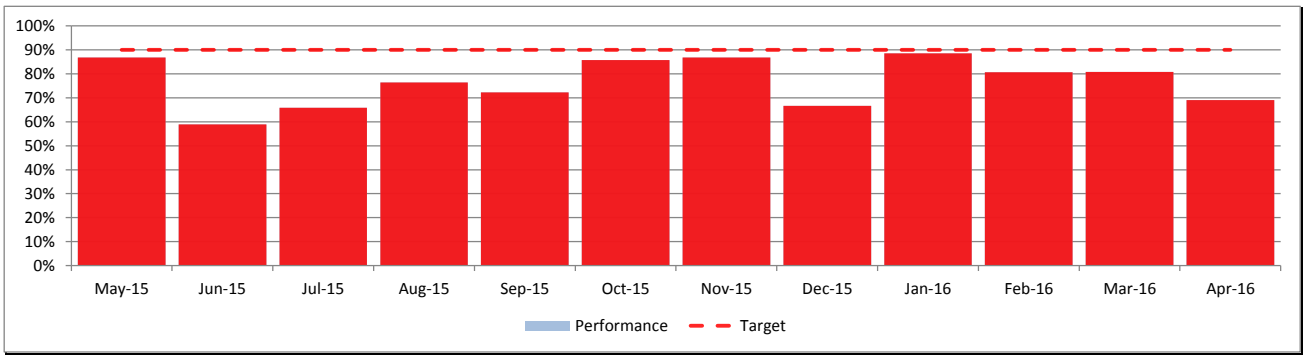
Fracture neck of femur

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients with a fractured neck of femur	38	40	41	34	36	28	38	42	35	31	47	42
Patients achieving best practice tariff	28	20	24	21	22	18	27	32	28	25	33	23
Performance	74%	50%	59%	62%	61%	64%	71%	76%	80%	81%	70%	55%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



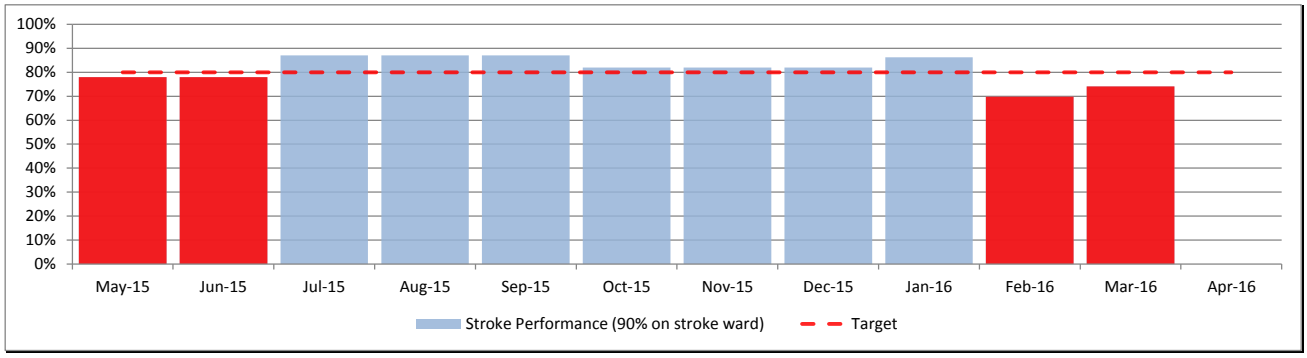
Fracture neck of femur - Admission to surgery less than 36 hours

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
To surgery within 36 hours	33	23	27	26	26	24	33	28	31	25	38	29
To surgery outside 36 hours	5	16	14	8	10	4	5	14	4	6	9	13
Performance	87%	59%	66%	76%	72%	86%	87%	67%	89%	81%	81%	69%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



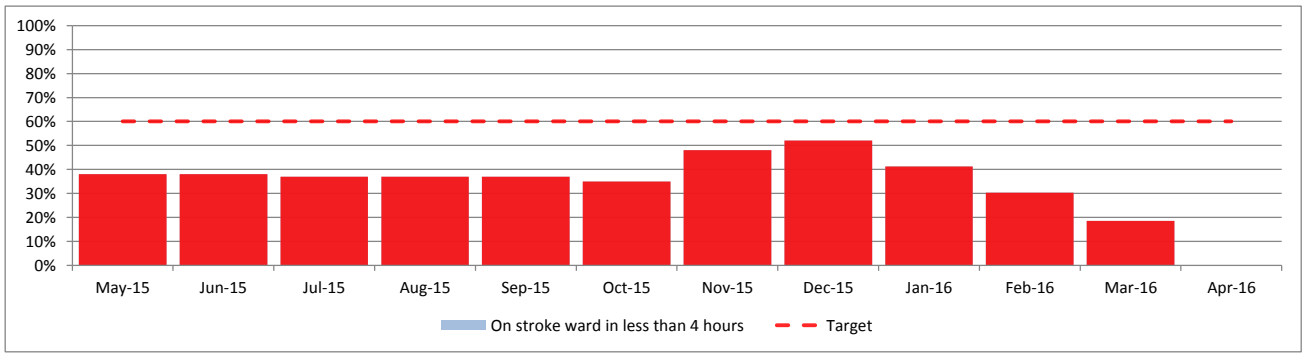
Stroke patients spending 90%+ of their time on a dedicated stroke ward - data based on SNAP audit

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Stroke Performance (90% on stroke ward)	78%	78%	87%	87%	87%	82%	82%	82%	86%	70%	74%	TBC
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



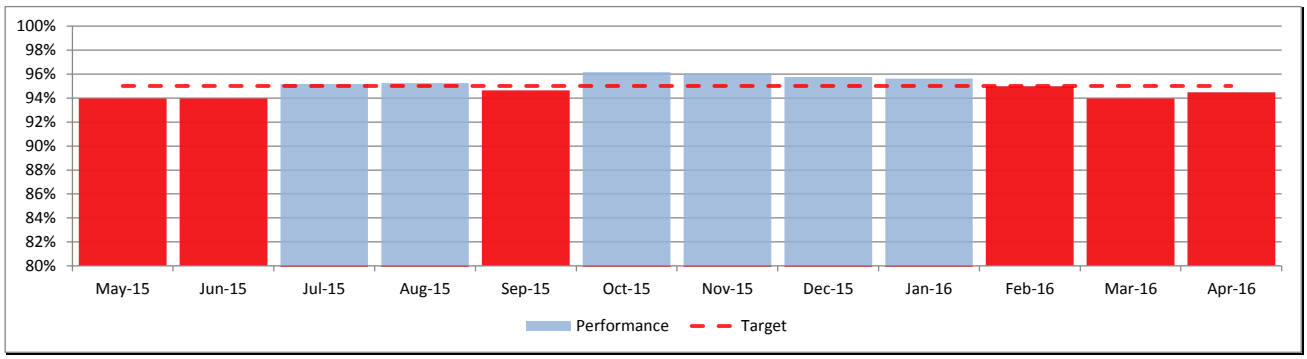
Time to stroke ward within 4 hours - data based on SNAP audit

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
On stroke ward in less than 4 hours	38%	38%	37%	37%	37%	35%	48%	52%	41%	30%	19%	TBC
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



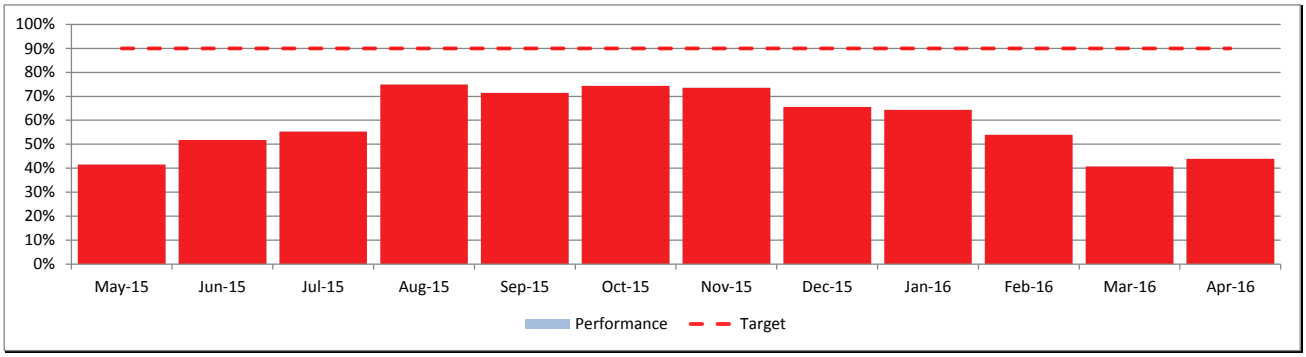
VTE risk assessment on admission - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Adult patients admitted	5334	6076	6257	5803	6266	5967	5821	5589	5911	5710	5930	5858
No risk assessed for VTE using national tool	5013	5709	5955	5528	5930	5738	5593	5352	5653	5424	5573	5535
Performance	94%	94%	95%	95%	95%	96%	96%	96%	96%	95%	94%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



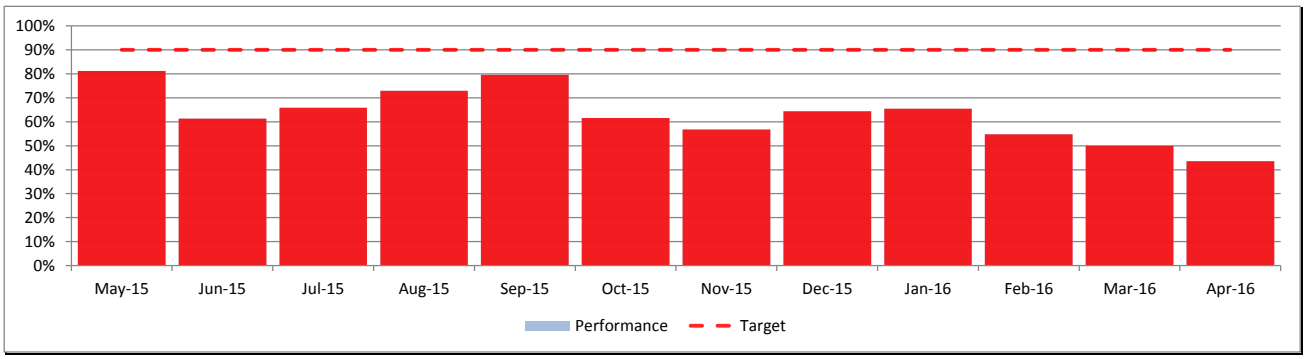
Dementia - Find

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Emergency admissions with LoS >3days (75+)	251	224	239	278	283	316	306	348	322	315	334	401
Finding question completed within 72 hours	104	116	132	208	202	235	225	228	207	170	136	176
Performance	41%	52%	55%	75%	71%	74%	74%	66%	64%	54%	41%	44%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



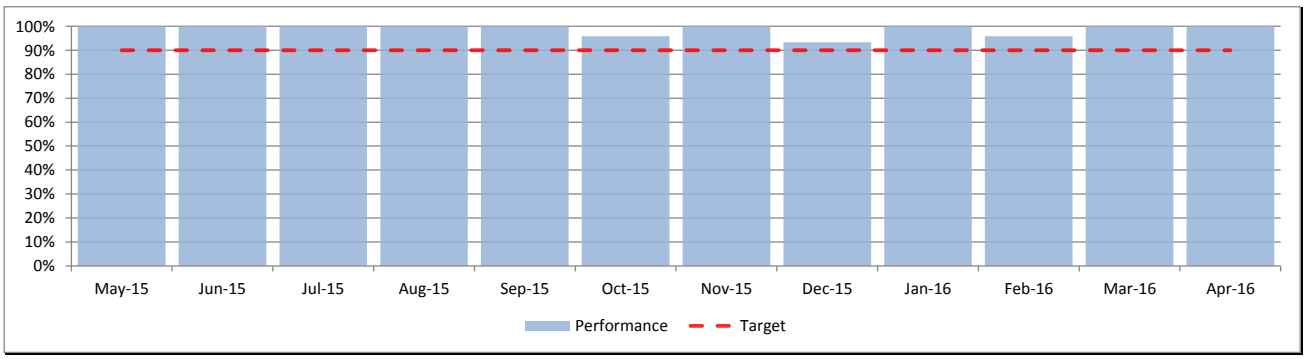
Dementia - Access and Investigate

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
+ve finding question or diagnosed delirium	32	31	38	48	49	65	44	59	58	53	44	39
Diagnostic assessment	26	19	25	35	39	40	25	38	38	29	22	17
Performance	81%	61%	66%	73%	80%	62%	57%	64%	66%	55%	50%	44%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



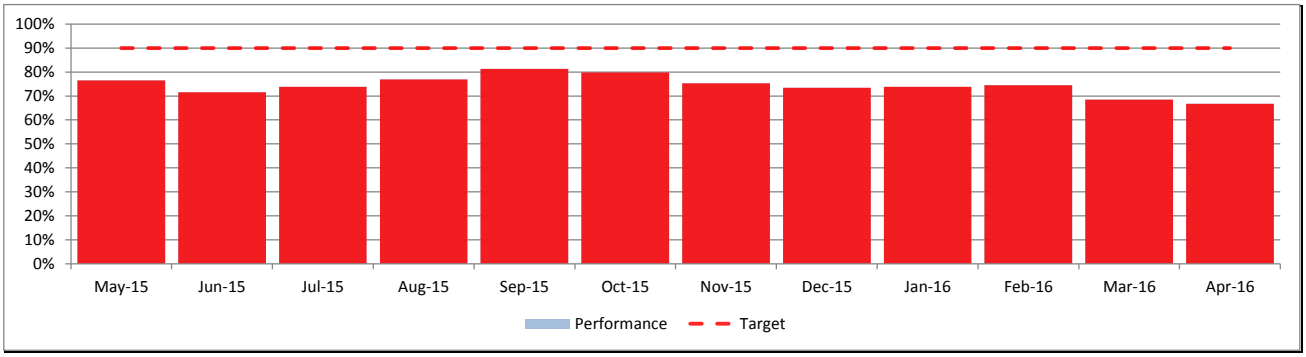
Dementia - Refer

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
+ve / inconclusive result from assessments	23	17	23	24	35	24	23	30	31	24	13	12
With a sufficient plan of care on discharge	23	17	23	24	35	23	23	28	31	23	13	12
Performance	100%	100%	100%	100%	100%	96%	100%	93%	100%	96%	100%	100%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



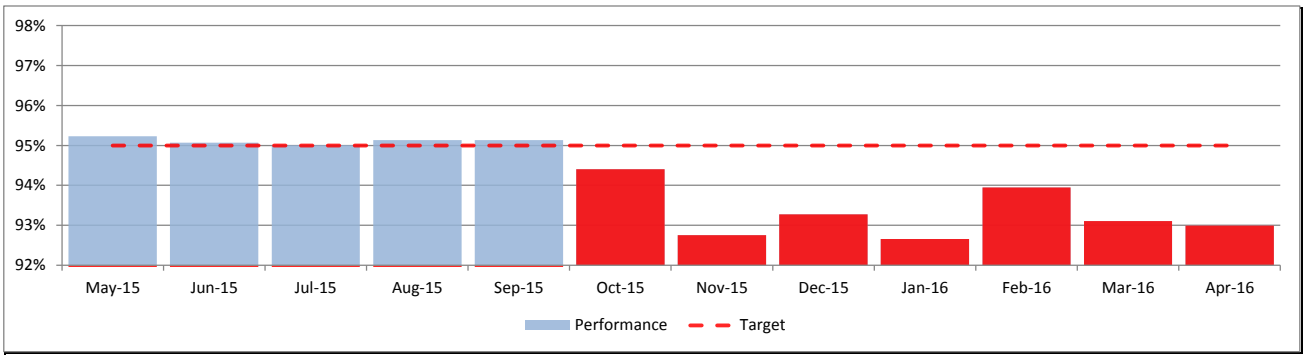
Admitted 18 week referral to treatment - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
RTT admitted clock stops	1246	1587	1594	1459	1616	1367	1365	1261	1352	1347	1350	1263
RTT admitted breaches	293	451	418	338	302	275	337	336	355	344	426	421
Performance	76%	72%	74%	77%	81%	80%	75%	73%	74%	74%	68%	67%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



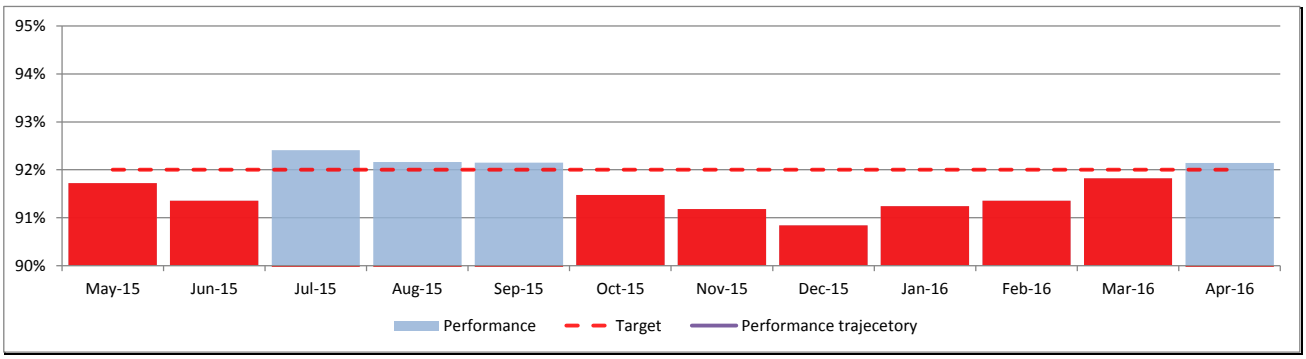
Non-admitted 18 week referral to treatment - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
RTT non-admitted clock stops	4992	5716	6229	4887	5935	6108	5326	4699	5187	4960	5017	5255
RTT non-admitted breaches	238	282	311	238	289	342	386	316	381	300	346	368
Performance	95%	95%	95%	95%	95%	94%	93%	93%	93%	94%	93%	93%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Incomplete 18 week referral to treatment - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
RTT incomplete pathways	15648	15572	17424	17104	16114	15458	15464	15965	15664	15944	15811	16031
RTT incomplete pathway breaches	1295	1346	1323	1341	1265	1318	1364	1462	1372	1378	1293	1260
Performance	92%	91%	92%	92%	92%	91%	91%	91%	91%	91%	92%	92%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Performance trajecetory												91%



RTT admitted performance - by specialty

	<126 days	>126 days	Total	Performance
Breast Surgery	36	0	36	100%
Cardiology	20	6	26	**77%**
Colorectal Surgery	36	7	43	**84%**
Dermatology	2	1	3	**67%**
ENT	66	18	84	**79%**
Gastroenterology	63	9	72	**88%**
General Medicine	6	0	6	100%
General Surgery	0	0	0	n/a
Geriatric Medicine	0	0	0	n/a
Gynaecology	109	10	119	92%
Interventional Radiology	26	1	27	96%
Neonatology	1	0	1	100%
Neurology	0	0	0	n/a
Ophthalmology	92	187	279	**33%**
Oral Surgery	77	14	91	**85%**
Paediatrics	2	0	2	100%
Pain Management	11	13	24	**46%**
Plastic Surgery	43	10	53	**81%**
Respiratory Medicine	7	0	7	100%
Rheumatology	10	0	10	100%
Thoracic Medicine	0	0	0	n/a
Trauma & Orthopaedics	119	101	220	**54%**
Upper Gastrointestinal Surgery	26	31	57	**46%**
Urology	81	12	93	**87%**
Vascular Surgery	9	1	10	90%
Total	842	421	1263	**67%**

RTT non-admitted performance - by specialty

	<126 days	>126 days	Total	Performance
Anaesthetics	5	0	5	100%
Breast Surgery	304	0	304	100%
Cardiology	178	46	224	**79%**
Clinical Haematology	61	0	61	100%
Clinical Neuro-Physiology	8	1	9	**89%**
Clinical Oncology (Radiotherapy)	13	1	14	**93%**
Colorectal Surgery	168	20	188	**89%**
Dermatology	500	10	510	98%
Diabetic Medicine	34	0	34	100%
Endocrinology	80	1	81	99%
ENT	368	45	413	**89%**
Gastroenterology	324	19	343	**94%**
General Medicine	95	1	96	99%
Geriatric Medicine	16	2	18	**89%**
Gynaecological Oncology	4	0	4	100%
Gynaecology	439	7	446	98%
Interventional Radiology	33	5	38	**87%**
Medical Oncology	1	0	1	100%
Nephrology	15	0	15	100%
Neurology	61	14	75	**81%**
Non Consultant	22	2	24	**92%**
Obstetrics	2	0	2	100%
Ophthalmology	527	46	573	**92%**
Oral Surgery	294	11	305	96%
Orthodontics	14	5	19	**74%**
Paediatrics	303	15	318	95%
Pain Management	52	21	73	**71%**
Plastic Surgery	17	1	18	**94%**
Podiatry	1	0	1	100%
Respiratory Medicine	109	13	122	**89%**
Restorative Dentistry	15	1	16	**94%**
Rheumatology	256	1	257	100%
Trauma & Orthopaedics	243	58	301	**81%**
Upper Gastrointestinal Surgery	43	9	52	**83%**
Urology	183	10	193	**95%**
Vascular Surgery	99	3	102	97%
Total	4887	368	5255	**93%**

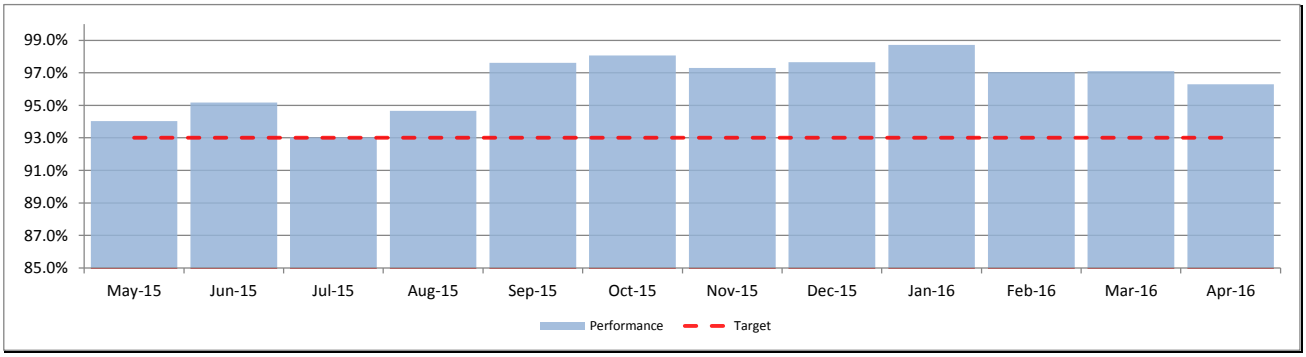
RTT incomplete performance - by specialty

	<126 days	>126 days	Total	Performance
Accident & Emergency	1	0	1	100%
Anaesthetics	35	3	38	92%
Breast Surgery	332	0	332	100%
Cardiology	1025	89	1114	92%

Cardiothoracic Surgery	15	1	16	94%
Clinical Haematology	107	1	108	99%
Clinical Neuro-Physiology	25	7	32	**78%**
Clinical Oncology (Radiotherapy)	28	1	29	97%
Colorectal Surgery	399	90	489	**82%**
Dermatology	938	5	943	99%
Diabetic Medicine	66	5	71	93%
Endocrinology	278	8	286	97%
ENT	1129	77	1206	94%
Gastroenterology	881	54	935	94%
General Medicine	79	5	84	94%
Geriatric Medicine	53	2	55	96%
Gynaecology	853	16	869	98%
Interventional Radiology	52	0	52	100%
Medical Oncology	13	0	13	100%
Nephrology	27	1	28	96%
Neurology	433	24	457	95%
Non Consultant	342	12	354	97%
Ophthalmology	1546	183	1729	**89%**
Oral Surgery	766	32	798	96%
Orthodontics	187	11	198	94%
Paediatrics	798	36	834	96%
Pain Management	464	80	544	**85%**
Plastic Surgery	157	21	178	**88%**
Rehabilitation	3	0	3	100%
Respiratory Medicine	588	39	627	94%
Restorative Dentistry	30	6	36	**83%**
Rheumatology	318	1	319	100%
Trauma & Orthopaedics	1541	242	1783	**86%**
Upper Gastrointestinal Surgery	347	130	477	**73%**
Urology	770	75	845	91%
Vascular Surgery	145	3	148	98%
Total	14771	1260	16031	92%

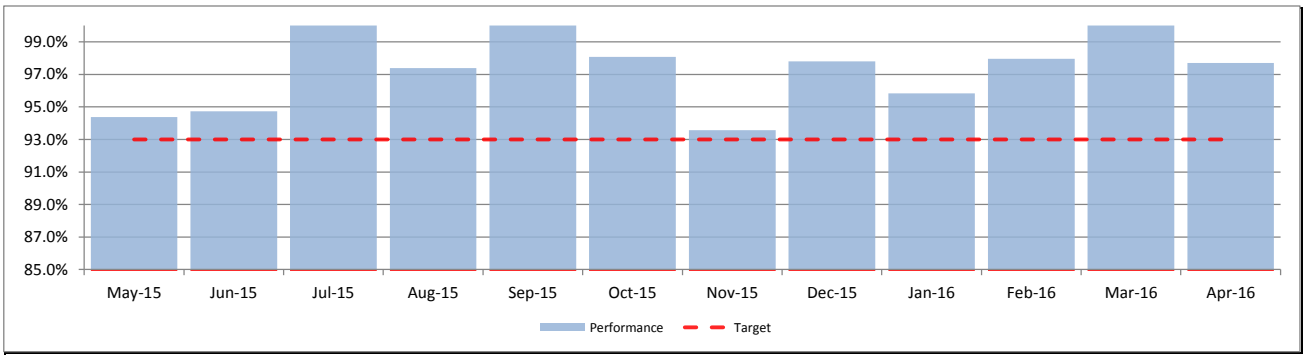
Two Week Wait Referrals - seen within 14 days

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
2ww referrals seen	753	913	903	826	884	879	889	897	705	846	965	889
2ww referral breaches	45	44	63	44	21	17	24	21	9	25	28	33
Performance	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.3%
Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%



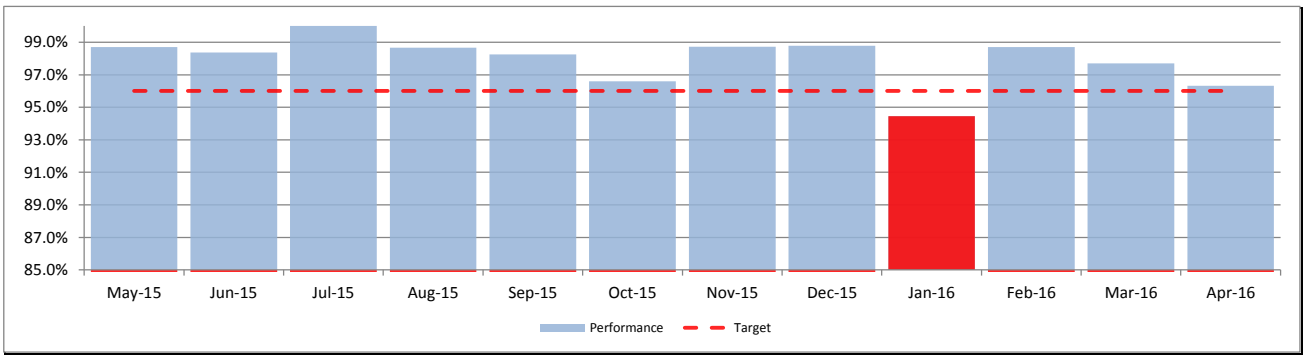
Breast Symptomatic referrals - seen within 14 days

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Breast symptomatic referrals seen	89	114	112	115	90	104	109	137	96	98	130	87
Breast symptomatic referrals breached	5	6	0	3	0	2	7	3	4	2	0	2
Performance	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%
Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%



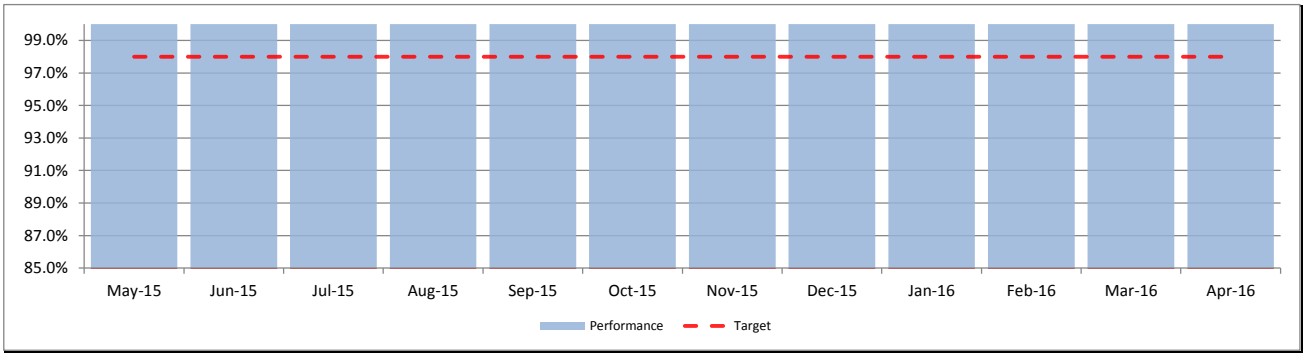
1st treatment - 31 day from decision to treat to treatment

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
1st treatments	155	185	169	149	172	176	156	163	162	155	174	190
31 day 1st treatment breaches	2	3	0	2	3	6	2	2	9	2	4	7
Performance	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.3%
Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%



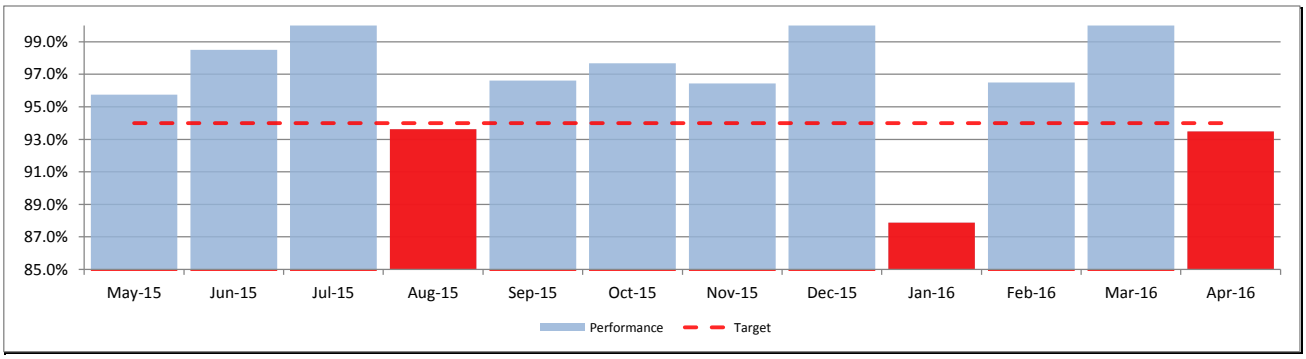
Subsequent treatment - 31 day from decision to treat to treatment - Drug

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Subsequent drug treatments	49	57	48	38	55	52	49	47	59	52	62	66
Subsequent drug breaches	0	0	0	0	0	0	0	0	0	0	0	0
Performance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%



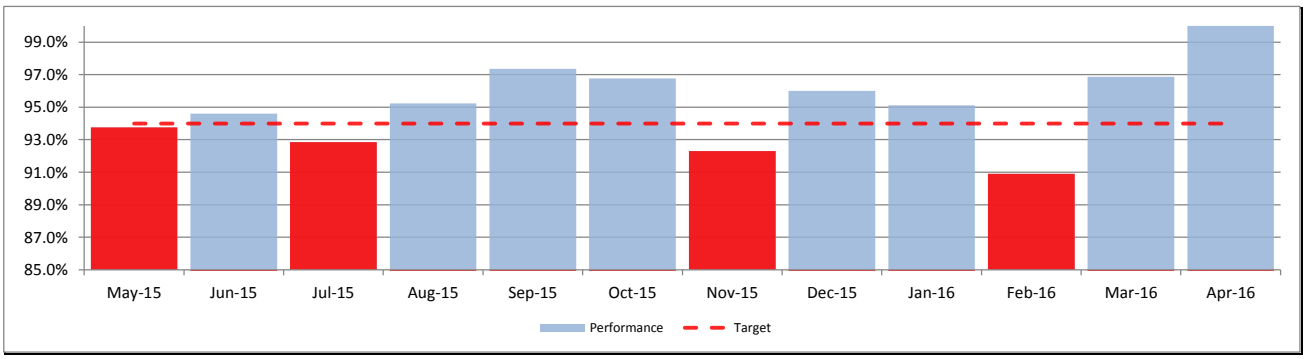
Subsequent treatment - 31 day from decision to treat to treatment - Radiotherapy

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Subsequent radiotherapy treatments	47	67	46	47	59	43	56	42	66	57	64	46
Subsequent radiotherapy breaches	2	1	0	3	2	1	2	0	8	2	0	3
Performance	95.7%	98.5%	100.0%	**93.6%**	96.6%	97.7%	96.4%	100.0%	**87.9%**	96.5%	100.0%	**93.5%**
Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%



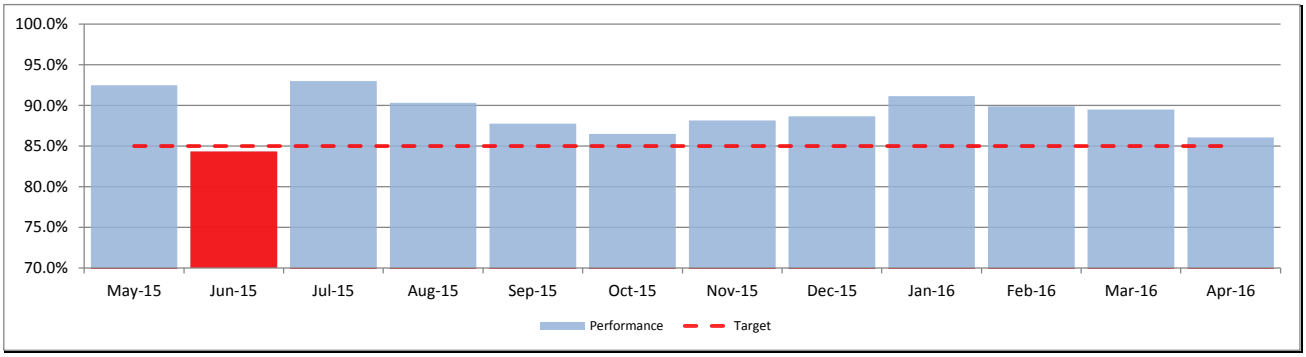
Subsequent treatment - 31 day from decision to treat to treatment - Surgery

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Subsequent surgery treatments	32	37	28	21	38	31	39	25	41	44	32	30
Subsequent surgery breaches	2	2	2	1	1	1	3	1	2	4	1	0
Performance	**93.8%**	94.6%	**92.9%**	95.2%	97.4%	96.8%	**92.3%**	96.0%	95.1%	**90.9%**	96.9%	100.0%
Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%



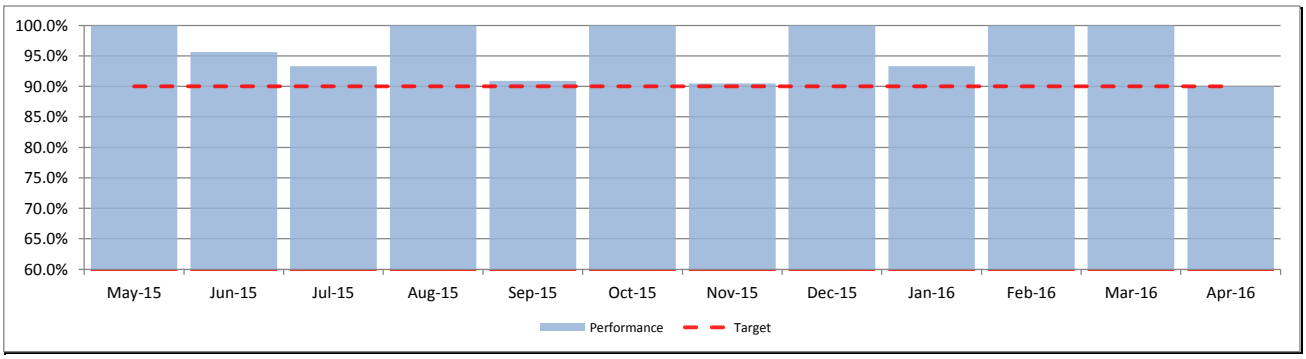
62 day 1st treatment from two week wait referral - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	73	92.5	85.5	77.5	98	100	76	75	79	79	90.5	104
62 day 1st treatment breaches	5.5	14.5	6	7.5	12	13.5	9	8.5	7	8	9.5	14.5
Performance	92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	86.1%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



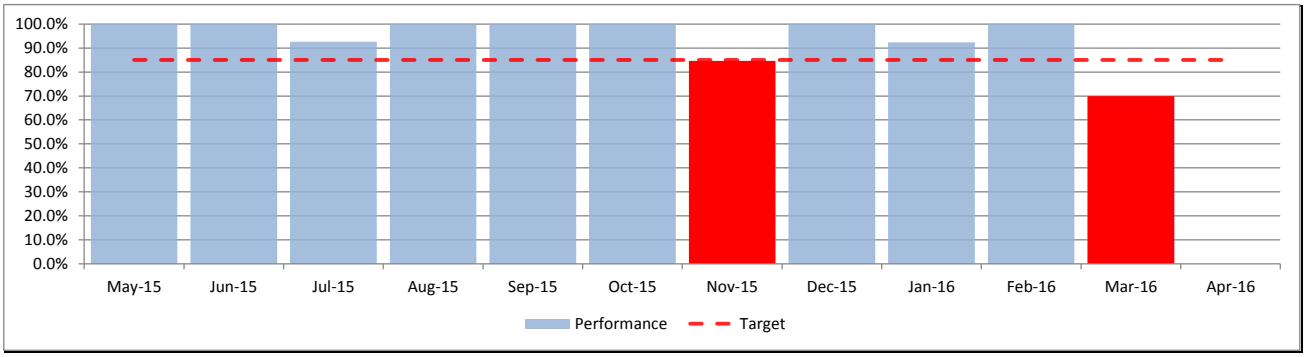
62 day 1st treatment from screening

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	11	11.5	7.5	8	11	11	10.5	15.5	15	7	13.5	20
62 day 1st treatment breaches	0	0.5	0.5	0	1	0	1	0	1	0	0	2
Performance	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



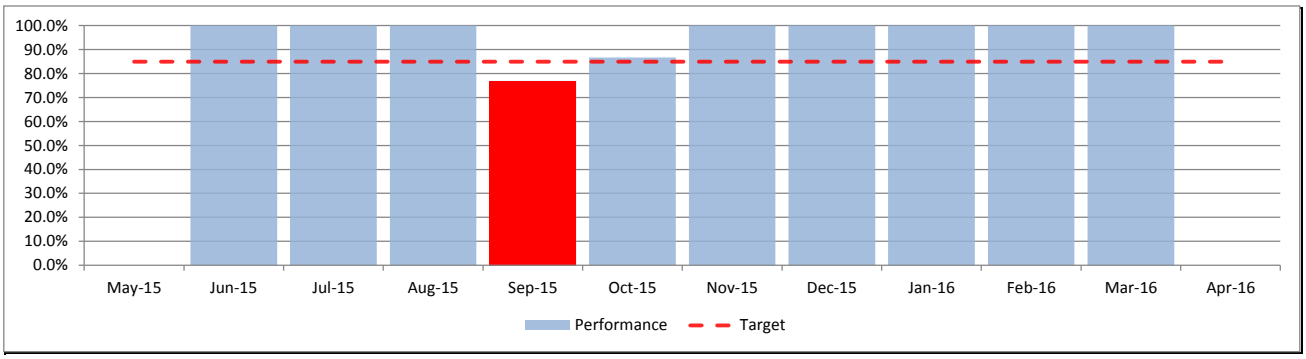
62 day 1st treatment from two week wait referral - BREAST

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	10	9	13.5	10	14	8	13	9	13	12	10	0
62 day 1st treatment breaches	0	0	1	0	0	0	2	0	1	0	3	0
Performance	100.0%	100.0%	92.6%	100.0%	100.0%	100.0%	**84.6%**	100.0%	92.3%	100.0%	**70.0%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



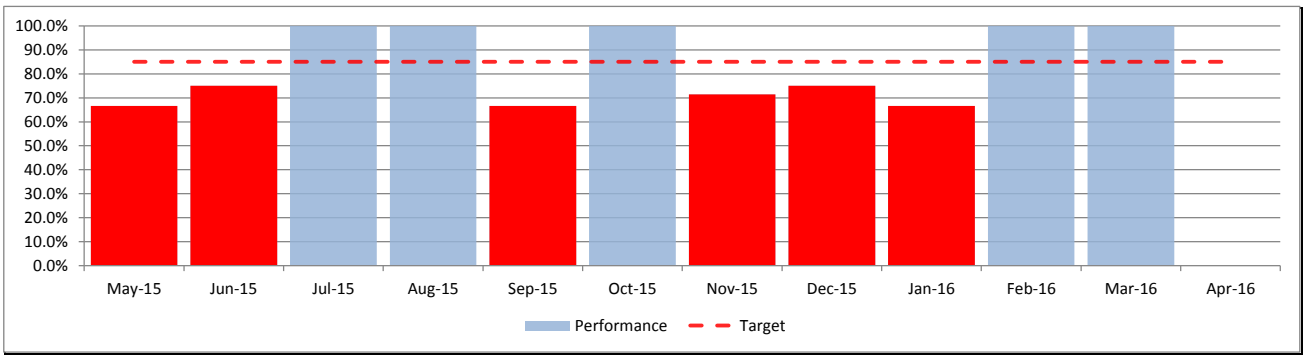
62 day 1st treatment from two week wait referral - GYNAECOLOGY

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	0	1.5	2	1	6.5	7.5	5	2.5	4	3	3.5	0
62 day 1st treatment breaches	0	0	0	0	1.5	1	0	0	0	0	0	0
Performance	#DIV/0!	100.0%	100.0%	100.0%	**76.9%**	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



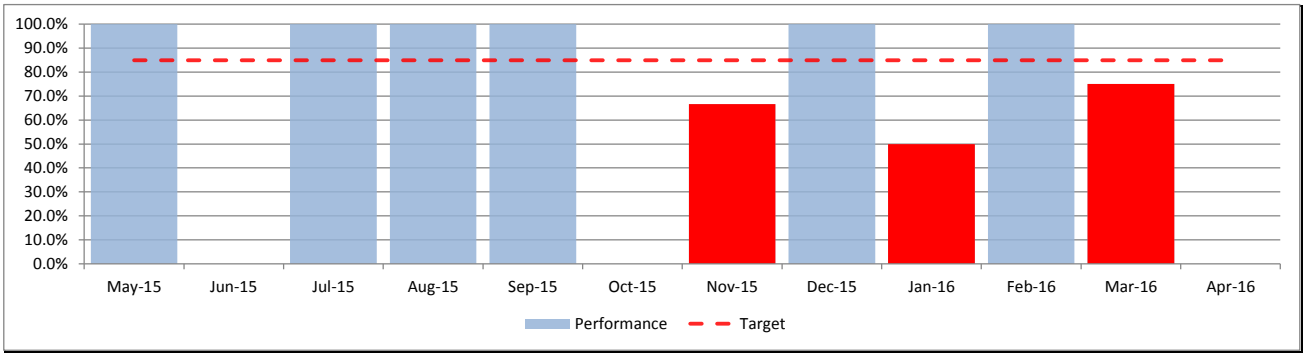
62 day 1st treatment from two week wait referral - HAEMATOLOGY

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	3	4	4	3	3	2	7	4	3	2	4	0
62 day 1st treatment breaches	1	1	0	0	1	0	2	1	1	0	0	0
Performance	**66.7%**	**75.0%**	100.0%	100.0%	**66.7%**	100.0%	**71.4%**	**75.0%**	**66.7%**	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



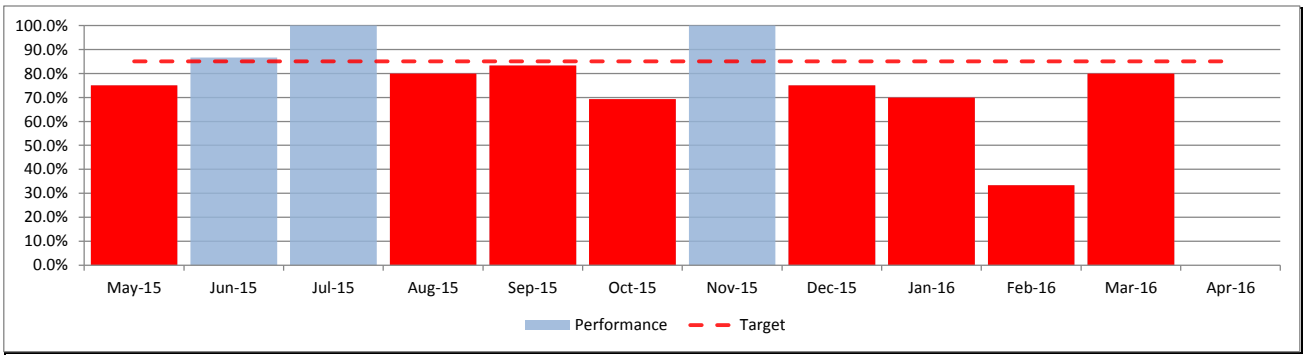
62 day 1st treatment from two week wait referral - HEAD AND NECK

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	1	4	5.5	2	2	0.5	3	1.5	2	1	4	0
62 day 1st treatment breaches	0	4	0	0	0	0.5	1	0	1	0	1	0
Performance	100.0%	**0.0%**	100.0%	100.0%	100.0%	**0.0%**	**66.7%**	100.0%	**50.0%**	100.0%	**75.0%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



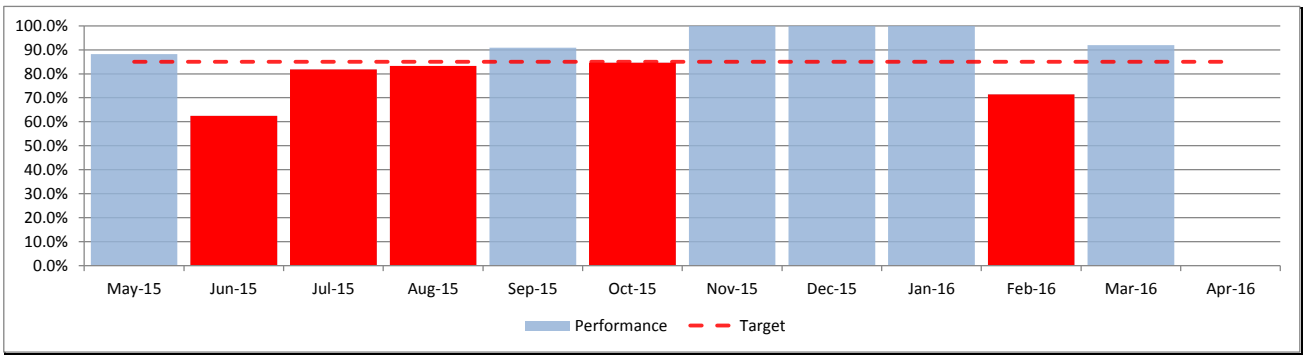
62 day 1st treatment from two week wait referral - LOWER GI

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	4	7.5	7	10	12	13	1	8	10	3	7.5	0
62 day 1st treatment breaches	1	1	0	2	2	4	0	2	3	2	1.5	0
Performance	**75.0%**	86.7%	100.0%	**80.0%**	**83.3%**	**69.2%**	100.0%	**75.0%**	**70.0%**	**33.3%**	**80.0%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



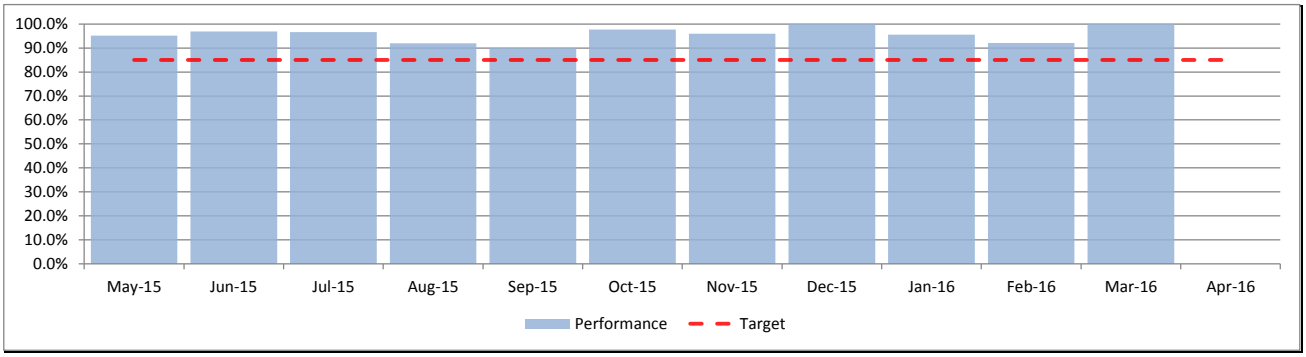
62 day 1st treatment from two week wait referral - LUNG

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	8.5	8	5.5	6	5.5	13	6	2	3	7	12.5	0
62 day 1st treatment breaches	1	3	1	1	0.5	2	0	0	0	2	1	0
Performance	88.2%	**62.5%**	**81.8%**	**83.3%**	90.9%	**84.6%**	100.0%	100.0%	100.0%	**71.4%**	92.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



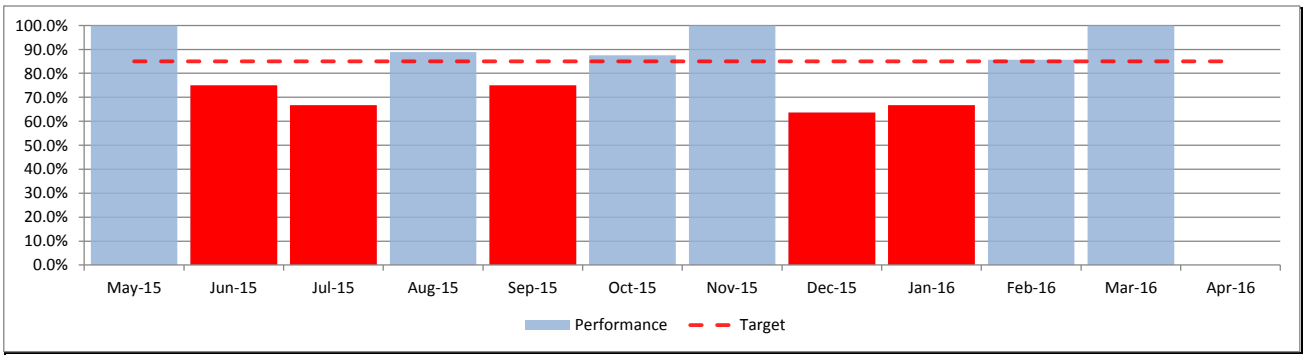
62 day 1st treatment from two week wait referral - SKIN

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	21	33	30	25	30	22.5	25	20	22.5	25.5	25	0
62 day 1st treatment breaches	1	1	1	2	3	0.5	1	0	1	2	0	0
Performance	95.2%	97.0%	96.7%	92.0%	90.0%	97.8%	96.0%	100.0%	95.6%	92.2%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



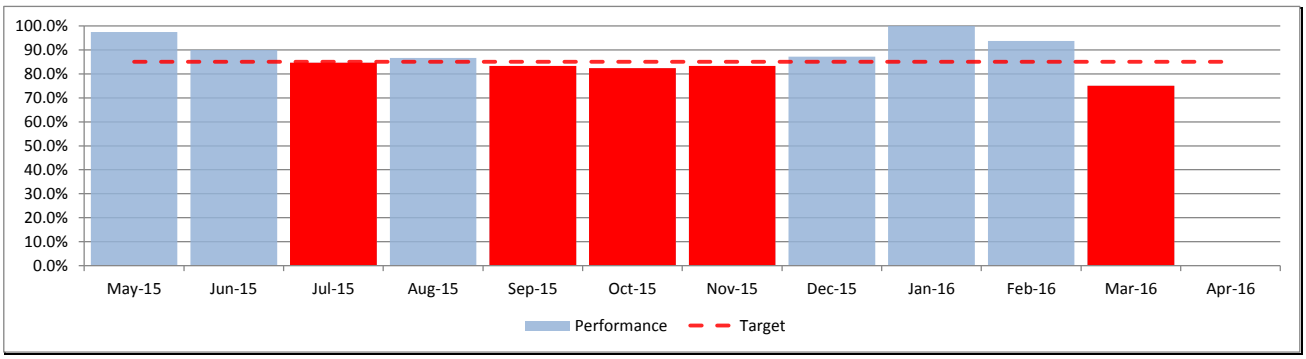
62 day 1st treatment from two week wait referral - UPPER GI

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	1	4	3	4.5	4	8	2	5.5	4.5	3.5	8	0
62 day 1st treatment breaches	0	1	1	0.5	1	1	0	2	1.5	0.5	0	0
Performance	100.0%	75.0%	66.7%	88.9%	75.0%	87.5%	100.0%	63.6%	66.7%	85.7%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



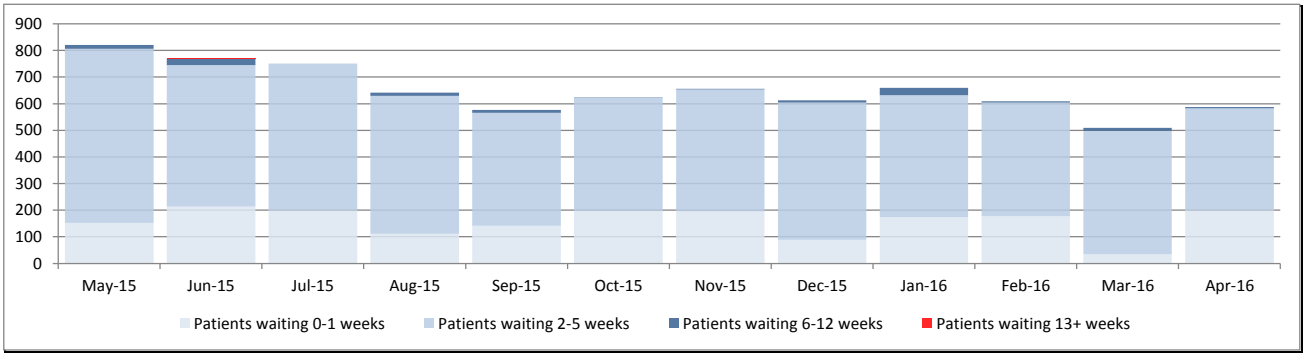
62 day 1st treatment from two week wait referral - UROLOGY

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
62 day 1st treatments	19.5	20	13	15	18	25.5	12	19.5	18	16	12	0
62 day 1st treatment breaches	0.5	2	2	2	3	4.5	2	2.5	0	1	3	0
Performance	97.4%	90.0%	84.6%	86.7%	83.3%	82.4%	83.3%	87.2%	100.0%	93.8%	75.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



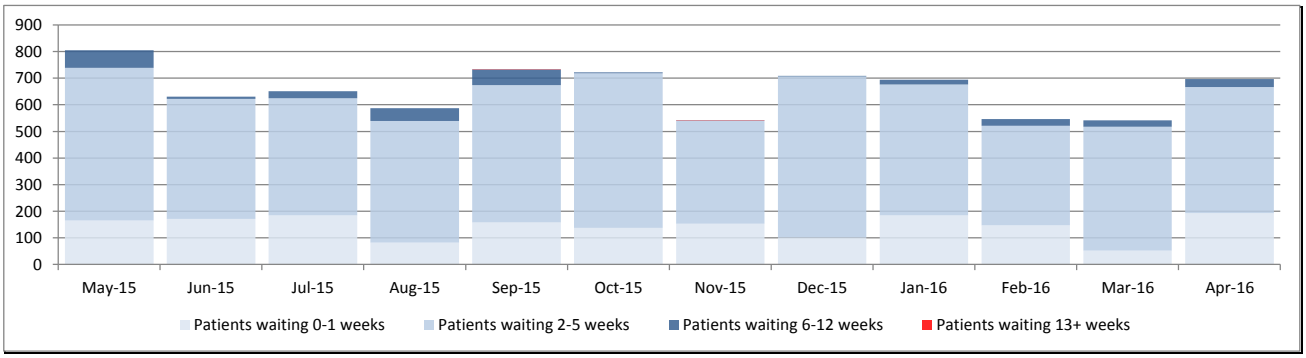
MRI Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	152	213	199	111	142	198	195	89	174	177	34	199
Patients waiting 2-5 weeks	654	532	552	519	424	425	459	515	458	427	464	384
Patients waiting 6-12 weeks	14	24	0	12	10	2	2	9	28	5	11	4
Patients waiting 13+ weeks	0	4	0	0	0	0	0	0	0	0	0	0



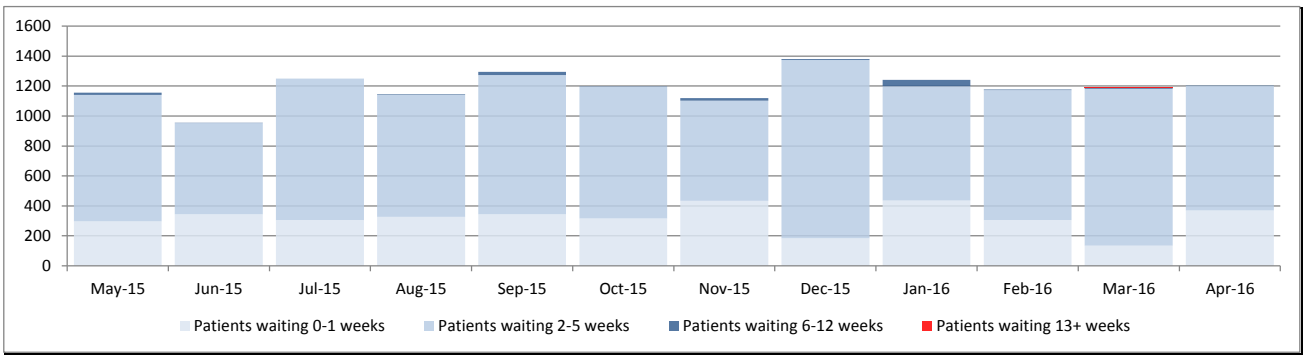
CT Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	165	171	184	82	158	138	153	102	184	147	52	193
Patients waiting 2-5 weeks	574	451	441	457	516	580	387	604	492	374	465	473
Patients waiting 6-12 weeks	66	9	26	48	59	4	1	2	18	25	24	30
Patients waiting 13+ weeks	0	0	0	0	1	0	1	0	0	0	0	0



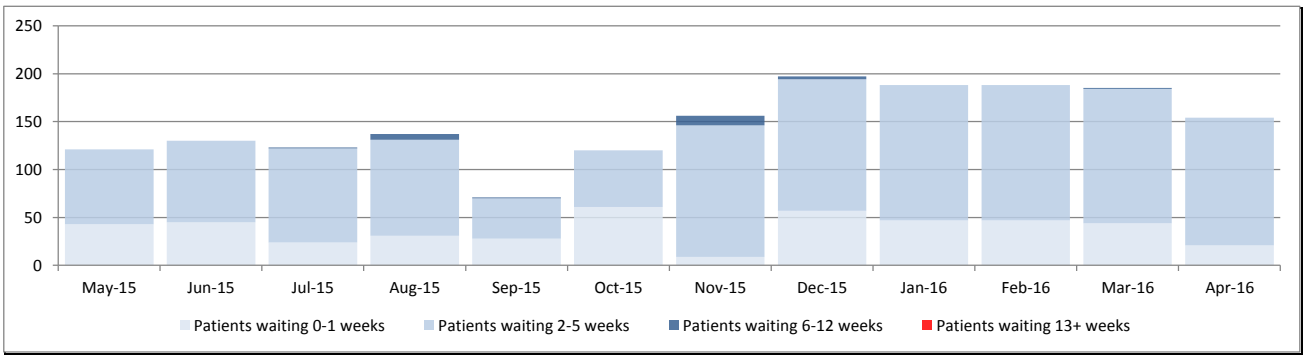
Non-Obstetric Ultrasound Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	296	344	306	327	345	316	434	184	436	306	134	369
Patients waiting 2-5 weeks	846	610	943	814	928	881	668	1191	762	868	1047	834
Patients waiting 6-12 weeks	15	1	0	5	21	2	17	5	44	3	10	2
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	1	0



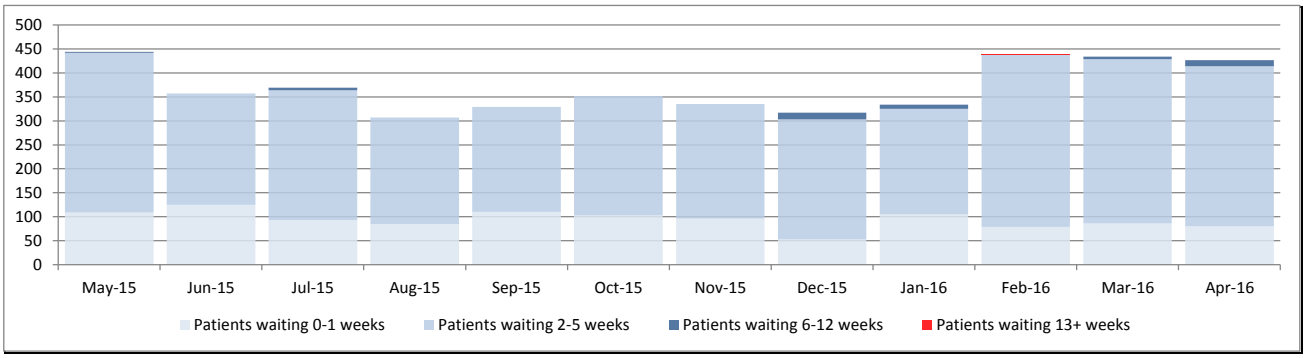
Dexa Scan Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	43	45	24	31	28	61	9	57	47	47	44	21
Patients waiting 2-5 weeks	78	85	98	100	42	59	137	137	141	141	140	133
Patients waiting 6-12 weeks	0	0	1	6	1	0	10	3	0	0	1	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



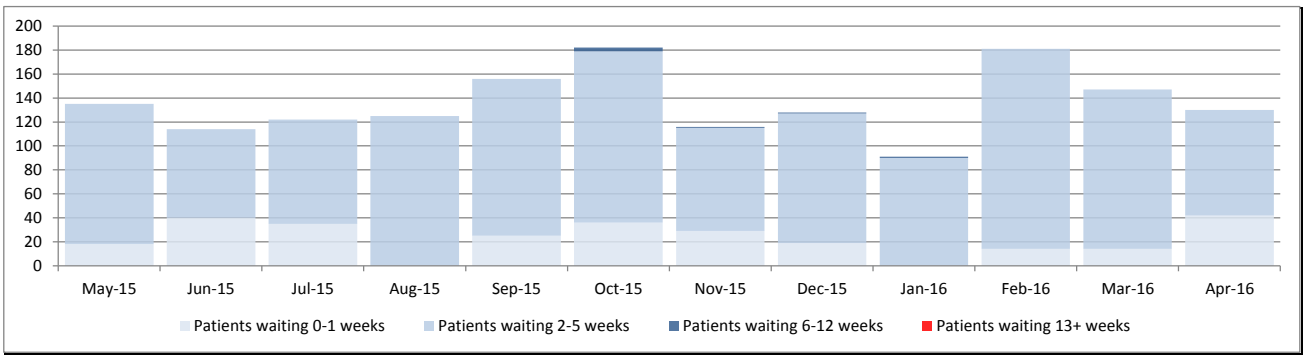
Audiology Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	109	125	93	85	110	103	96	53	105	79	86	80
Patients waiting 2-5 weeks	333	232	271	222	219	249	239	250	220	359	343	334
Patients waiting 6-12 weeks	2	0	5	0	0	0	0	14	9	0	5	13
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	2	0	0



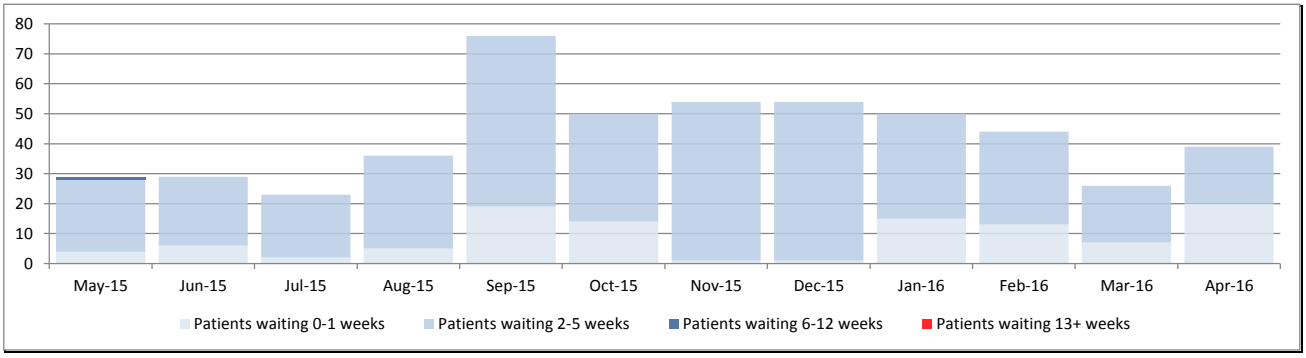
Cardiology (Echocardiology) Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	18	40	35	0	25	36	29	19	0	14	14	42
Patients waiting 2-5 weeks	117	74	87	125	131	143	86	108	90	167	133	88
Patients waiting 6-12 weeks	0	0	0	0	0	3	1	1	1	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



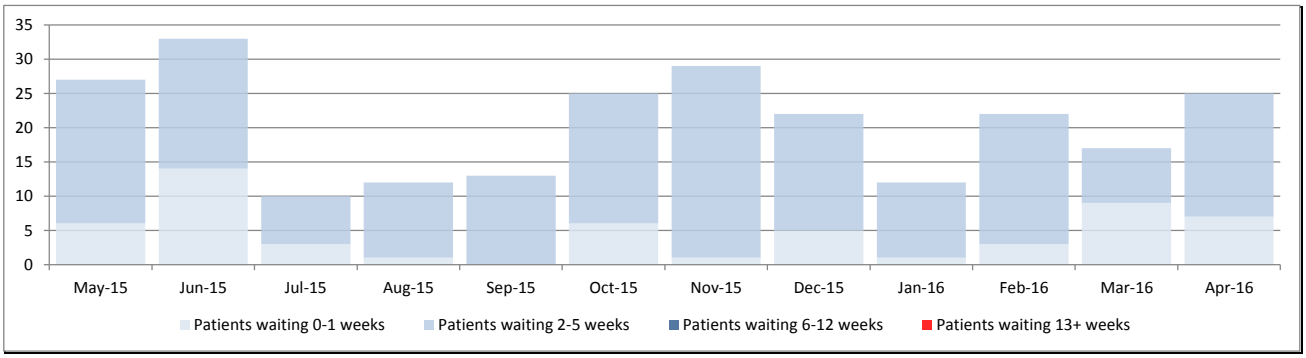
Neurophysiology Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	4	6	2	5	19	14	1	1	15	13	7	20
Patients waiting 2-5 weeks	24	23	21	31	57	36	53	53	35	31	19	19
Patients waiting 6-12 weeks	1	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



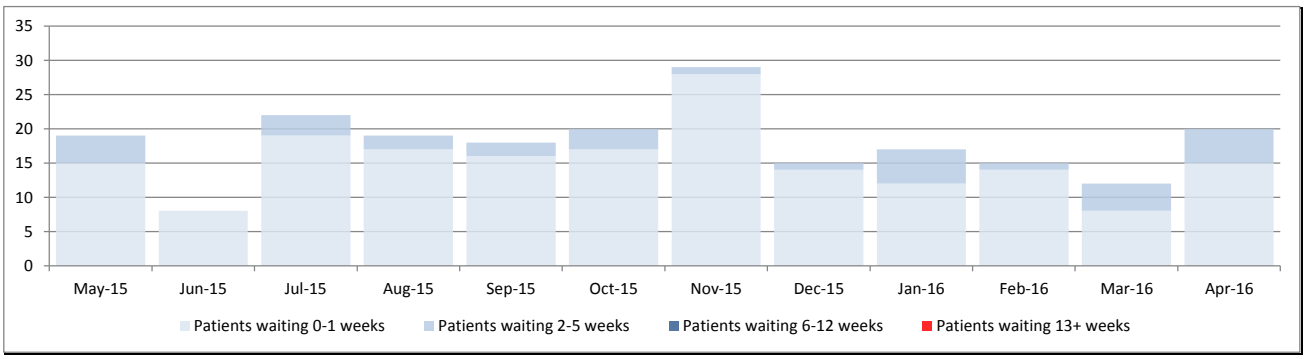
Respiratory Physiology - Sleep Studies

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	6	14	3	1	0	6	1	5	1	3	9	7
Patients waiting 2-5 weeks	21	19	7	11	13	19	28	17	11	19	8	18
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



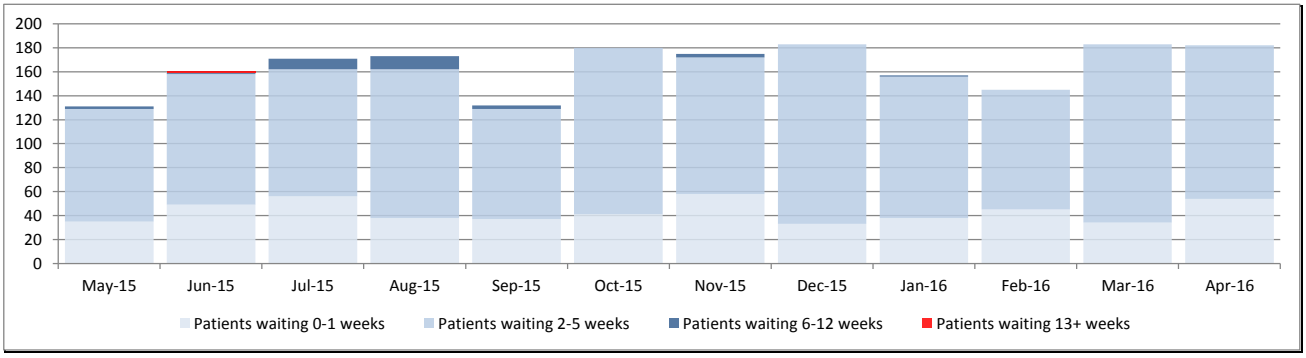
Urodynamics - Pressures & Flows

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	15	8	19	17	16	17	28	14	12	14	8	15
Patients waiting 2-5 weeks	4	0	3	2	2	3	1	1	5	1	4	5
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



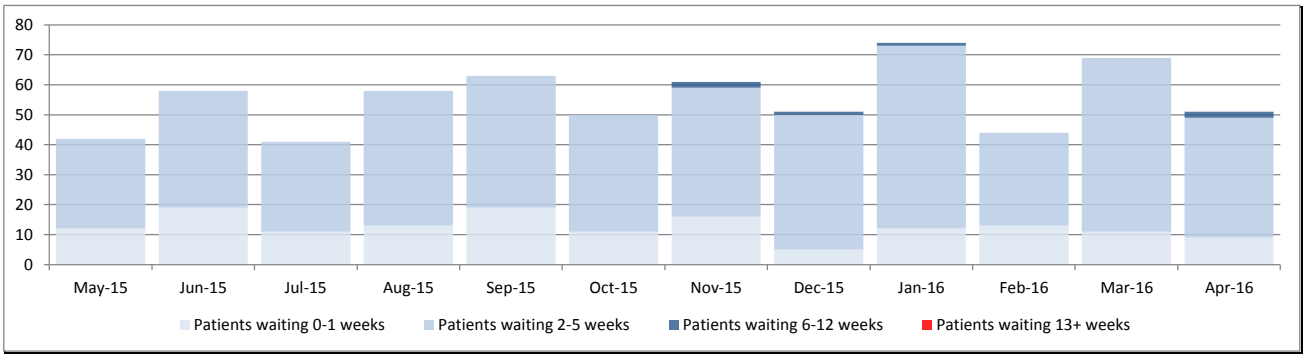
Colonoscopy Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	35	49	56	38	37	41	58	33	38	45	34	54
Patients waiting 2-5 weeks	94	109	106	124	92	139	114	150	118	100	149	128
Patients waiting 6-12 weeks	2	1	9	11	3	0	3	0	1	0	0	0
Patients waiting 13+ weeks	0	1	0	0	0	0	0	0	0	0	0	0



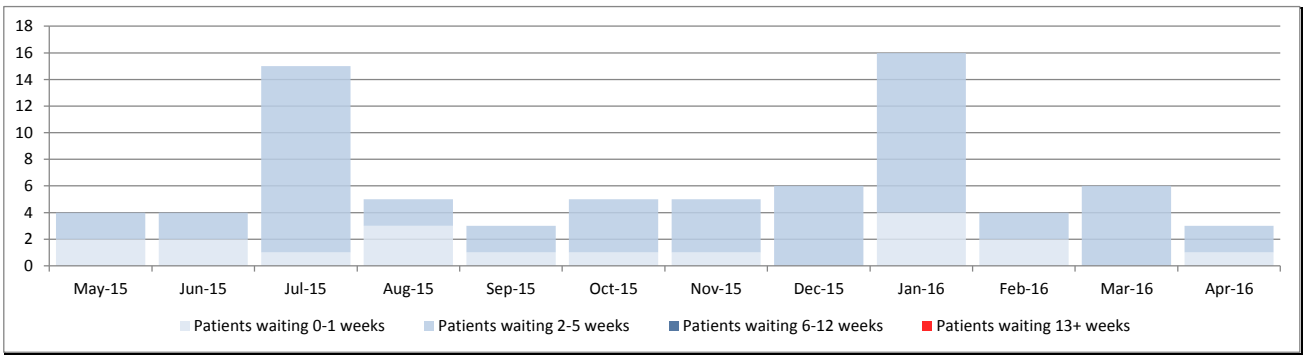
Flexi Sigmoidoscopy Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	12	19	11	13	19	11	16	5	12	13	11	9
Patients waiting 2-5 weeks	30	39	30	45	44	39	43	45	61	31	58	40
Patients waiting 6-12 weeks	0	0	0	0	0	0	2	1	1	0	0	2
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



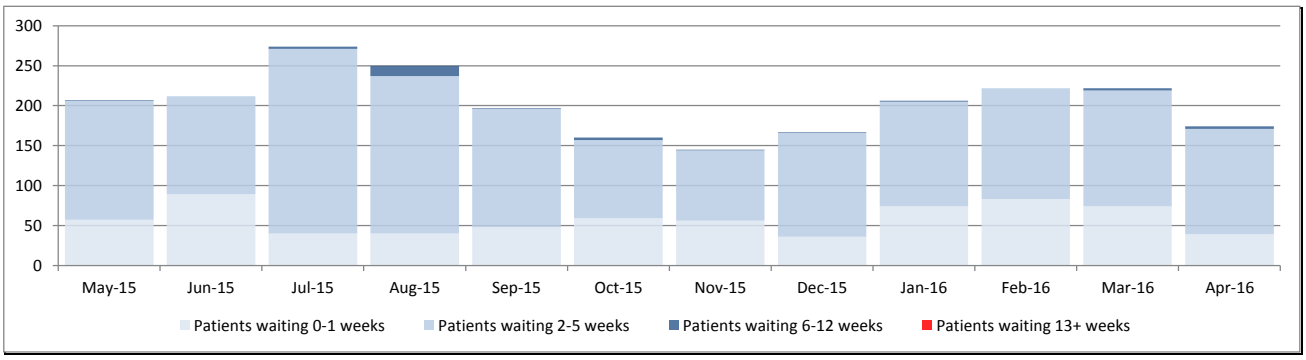
Cystoscopy Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	2	2	1	3	1	1	1	0	4	2	0	1
Patients waiting 2-5 weeks	2	2	14	2	2	4	4	6	12	2	6	2
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



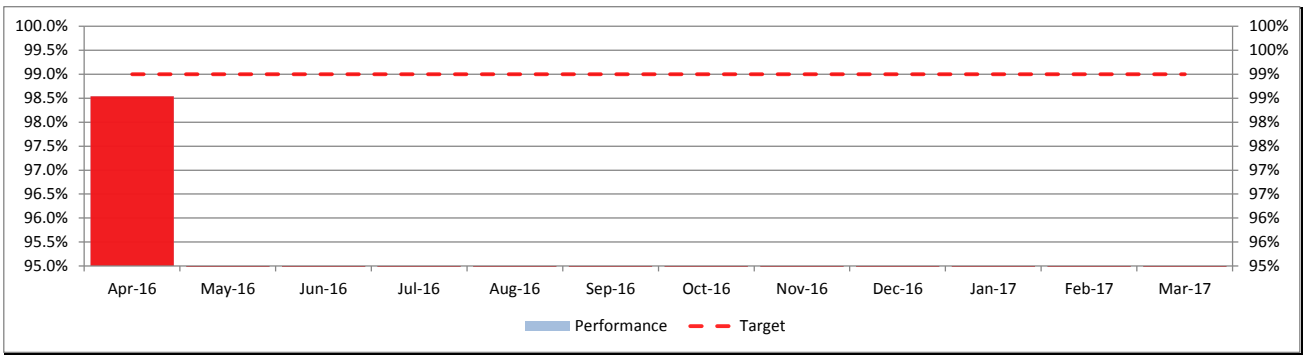
Gastroscopy Waiting Times

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients waiting 0-1 weeks	57	89	40	40	48	59	56	36	74	83	74	39
Patients waiting 2-5 weeks	149	123	231	197	148	98	88	130	131	139	145	132
Patients waiting 6-12 weeks	1	0	3	13	1	3	1	1	1	0	3	3
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



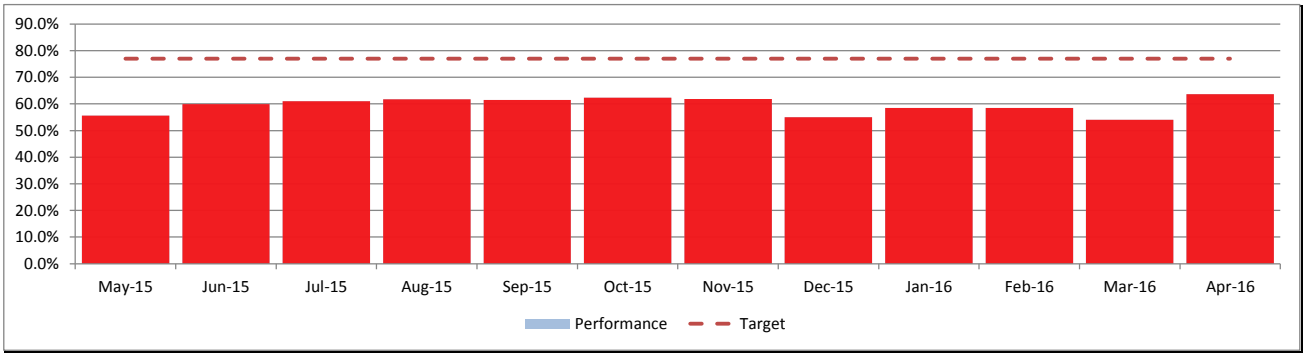
Overall diagnostic position

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total waits	3693											
Total breaches (6+ weeks)	54											
Performance	98.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%



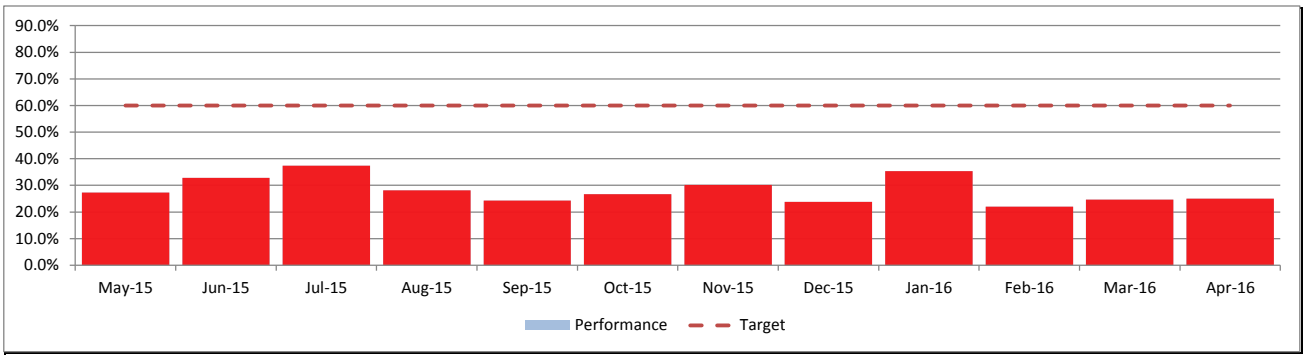
CPS completed within 24 hours - Weekday - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients	1701	1833	1913	1673	1893	1840	1831	1863	1705	1860	2008	1737
CPS completed within 24 hours	946	1099	1167	1032	1165	1148	1132	1025	997	1089	1085	1105
Performance	55.6%	60.0%	61.0%	61.7%	61.5%	62.4%	61.8%	55.0%	58.5%	58.5%	54.0%	63.6%
Target	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%



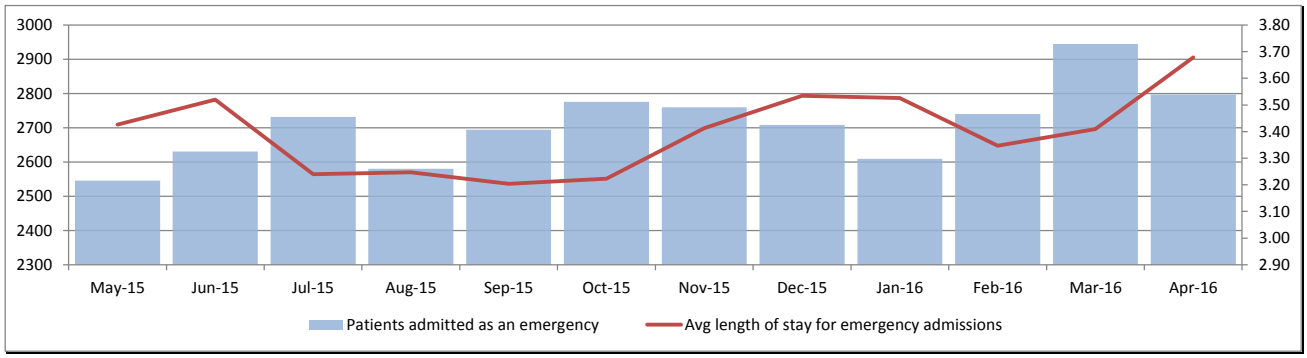
CPS completed within 24 hours - Weekend - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients	524	418	423	565	444	495	444	390	470	414	406	528
CPS completed within 24 hours	143	137	158	159	108	132	134	93	166	91	100	132
Performance	27.3%	32.8%	37.4%	28.1%	24.3%	26.7%	30.2%	23.8%	35.3%	22.0%	24.6%	25.0%
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



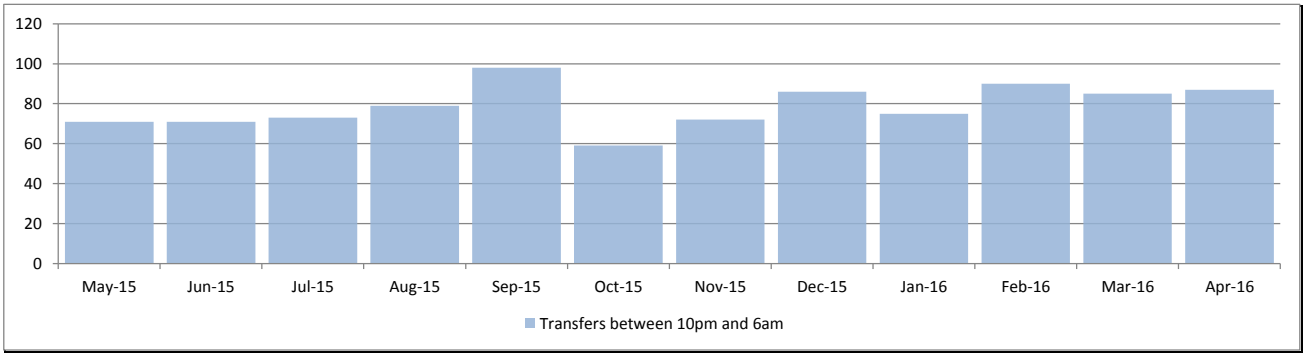
Emergency admissions - Trust Total

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Patients admitted as an emergency	2546	2631	2732	2580	2694	2776	2760	2708	2609	2740	2945	2797
Avg length of stay for emergency admissions	3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.53	3.53	3.35	3.41	3.68



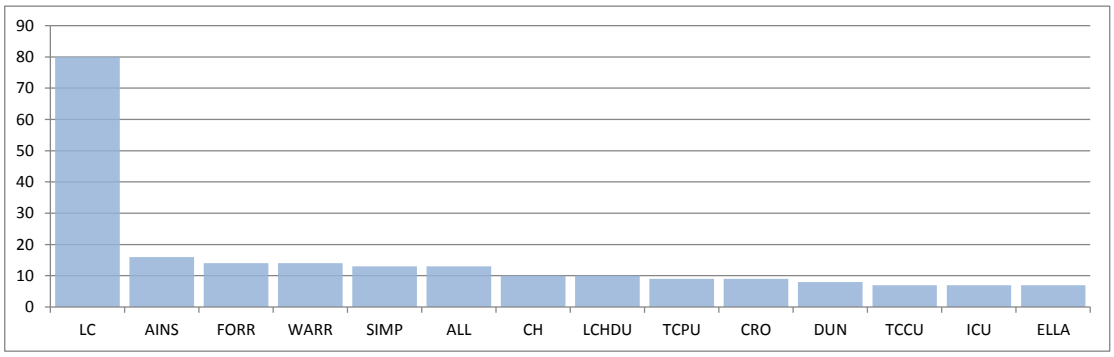
Acute Transfers

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Transfers between 10pm and 6am	71	71	73	79	98	59	72	86	75	90	85	87
Transfers between 10pm and midnight	31	38	34	38	41	26	33	28	37	36	40	46
Transfers between midnight and 2am	22	19	17	22	32	13	18	28	22	31	26	19
Transfers between 2am and 4am	10	11	12	15	16	10	10	13	10	10	11	14
Transfers between 4am and 6am	8	3	10	4	9	10	11	17	6	13	8	8



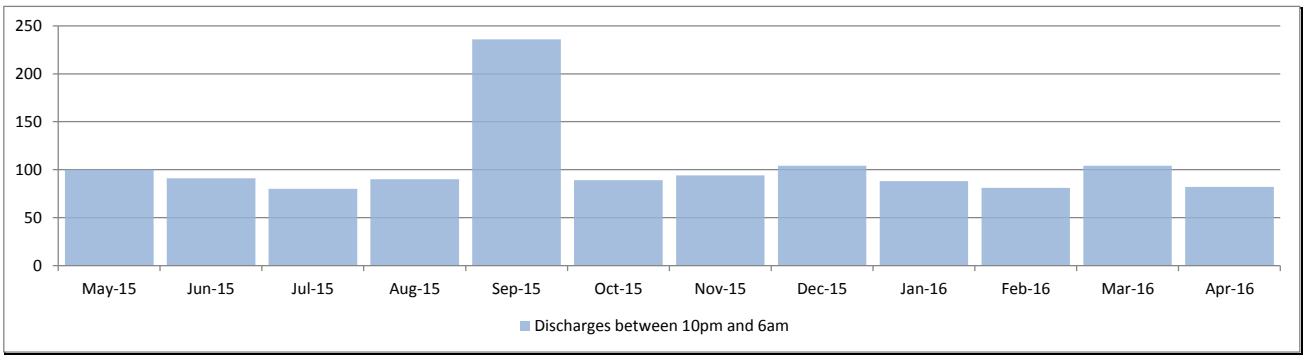
Acute Night time transfers by ward (last 3 months)

Ward	Transfers
LC	80
AINS	16
FORR	14
WARR	14
SIMP	13
ALL	13
CH	10
LCHDU	10
TCPU	9
CRO	9
DUN	8
TCCU	7
ICU	7
ELLA	7



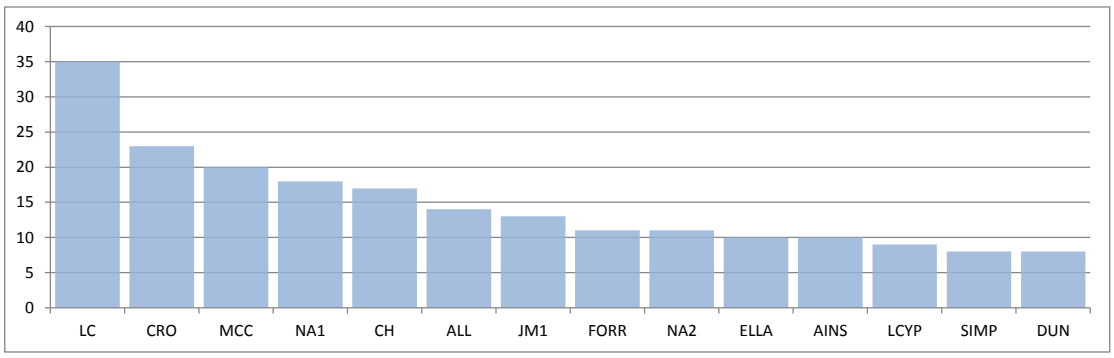
Acute Discharges

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Discharges between 10pm and 6am	100	91	80	90	236	89	94	104	88	81	104	82
Discharges between 10pm and midnight	52	46	53	32	192	52	46	46	40	44	54	38
Discharges between midnight and 2am	29	21	15	25	24	20	29	31	23	18	25	22
Discharges between 2am and 4am	15	16	7	23	12	11	9	18	21	13	13	11
Discharges between 4am and 6am	4	8	5	10	8	6	10	9	4	6	12	11



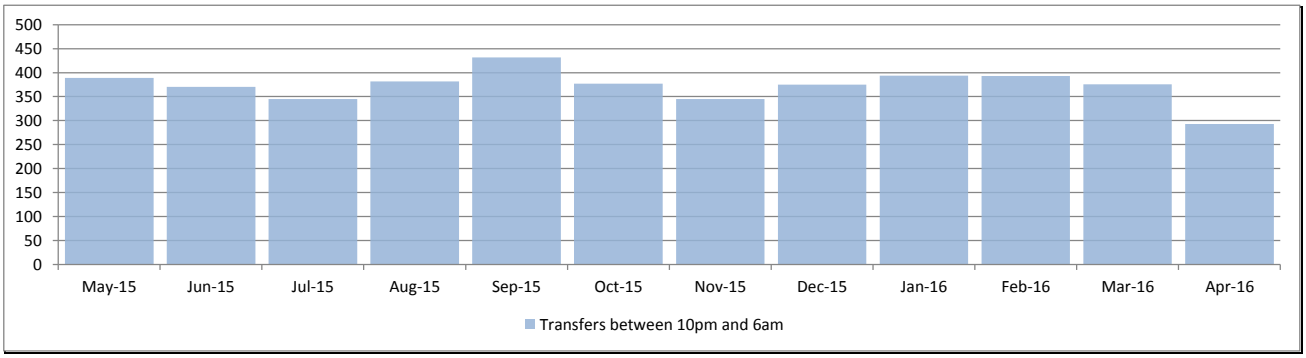
Acute Night time discharges by ward (last 3 months)

Ward	Discharges
LC	35
CRO	23
MCC	20
NA1	18
CH	17
ALL	14
JM1	13
FORR	11
NA2	11
ELLA	10
AINS	10
LCYP	9
SIMP	8
DUN	8



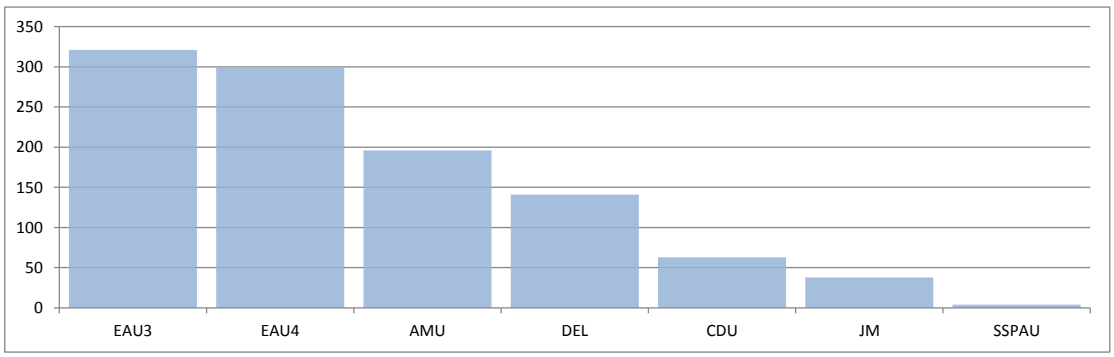
Short stay / assessment ward Transfers

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Transfers between 10pm and 6am	389	370	345	382	432	377	345	375	394	393	376	293
Transfers between 10pm and midnight	142	143	133	135	145	150	138	145	165	152	169	127
Transfers between midnight and 2am	126	120	115	115	147	98	94	125	109	145	104	99
Transfers between 2am and 4am	78	61	57	72	90	90	66	57	74	47	65	38
Transfers between 4am and 6am	43	46	40	60	50	39	47	48	46	49	38	29



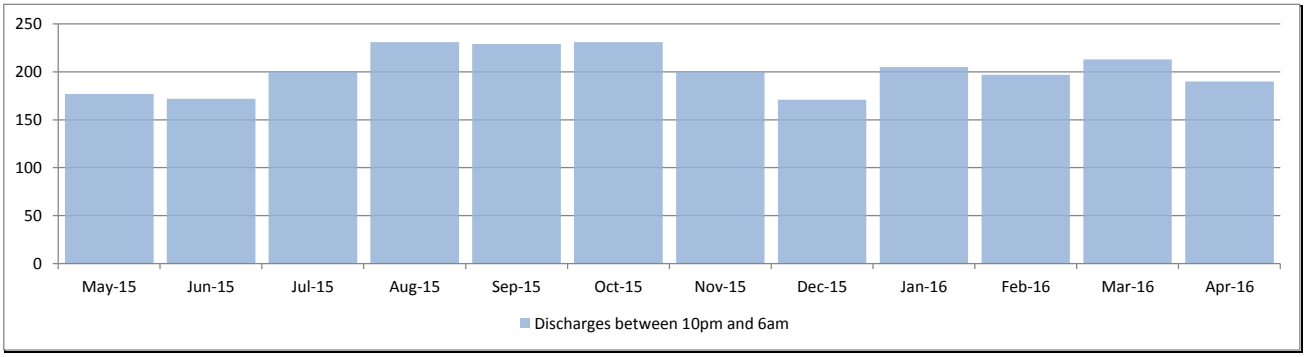
Short stay / assessment ward Night time transfers by ward (last 3 months)

Ward	Transfers
EAU3	321
EAU4	299
AMU	196
DEL	141
CDU	63
JM	38
SSPAU	4



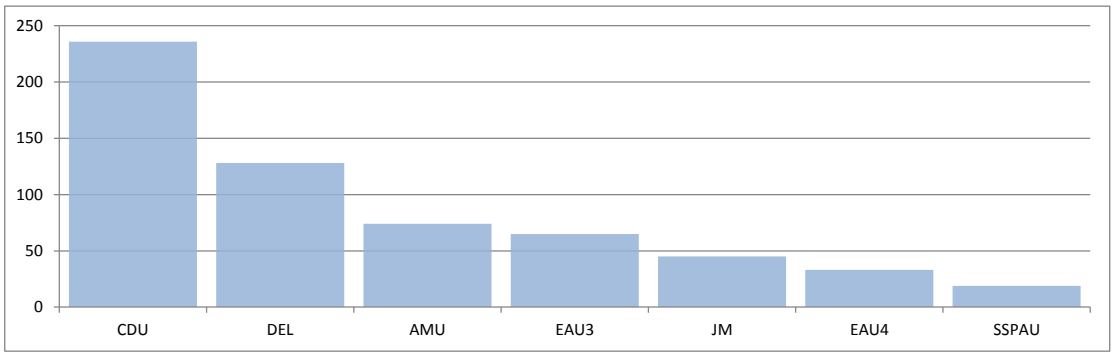
Short stay / assessment ward Discharges

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Discharges between 10pm and 6am	177	172	200	231	229	231	200	171	205	197	213	190
Discharges between 10pm and midnight	86	85	91	106	97	102	83	84	100	102	129	95
Discharges between midnight and 2am	47	42	58	67	64	58	62	45	61	53	45	42
Discharges between 2am and 4am	27	33	30	32	35	43	31	24	26	21	27	36
Discharges between 4am and 6am	17	12	21	26	33	28	24	18	18	21	12	17



Short stay / assessment ward Night time discharges by ward (last 3 months)

Ward	Transfers
CDU	236
DEL	128
AMU	74
EAU3	65
JM	45
EAU4	33
SSPAU	19



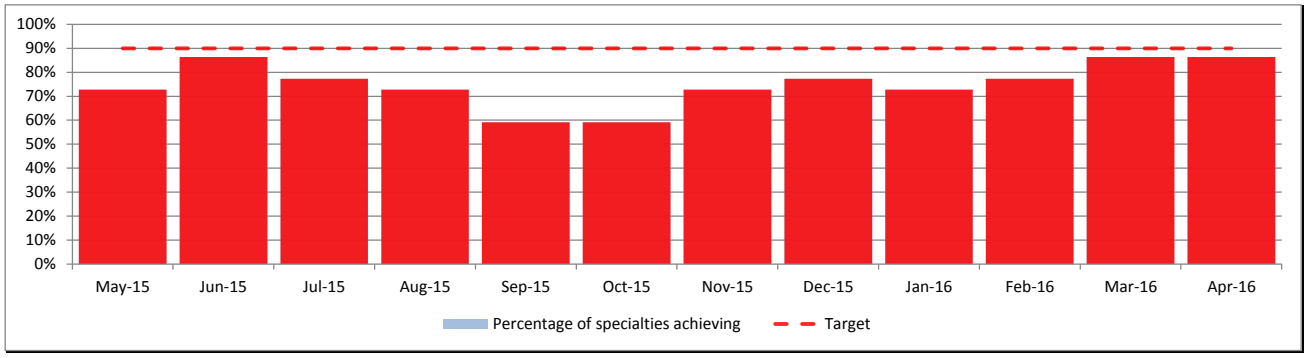
Night time discharges commentary

Higher number of night-time discharges are to be expected from emergency assessment units and maternity areas

The CDU and AMU are newly introduced clinical areas where patients receive extended assessment and operate 24 /7

Clinic Letters Timeliness - Dictated Letters Not Typed

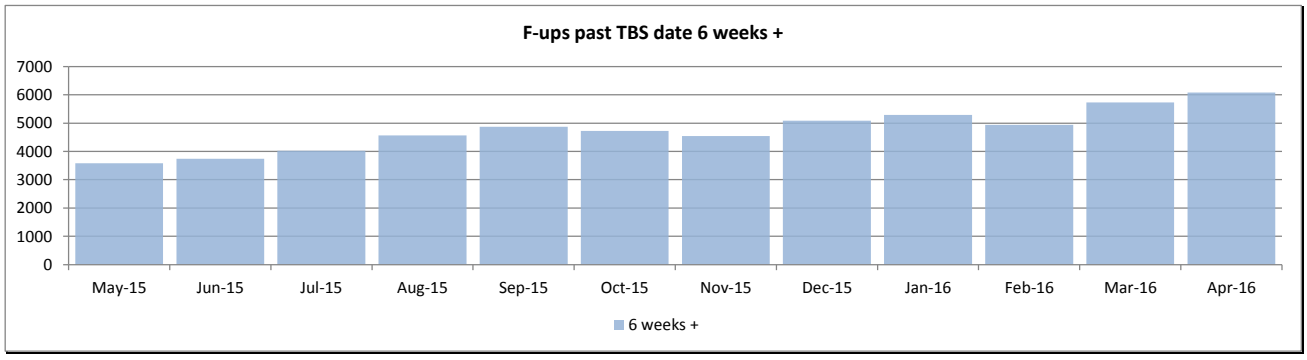
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Specialties breaching	6	3	5	6	9	9	6	5	6	5	3	3
Percentage of specialties achieving	73%	86%	77%	73%	59%	59%	73%	77%	73%	77%	86%	86%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Follow up appointments past to be seen date

	0-6 Weeks	6-12 Weeks	12-18 Weeks	18 Weeks +	Grand Total
Audiology	202	11	8	1	222
Breast Surgery	244	31	1	0	276
Cardiology	73	55	64	79	271
Colorectal Surgery	3	1	1	4	9
Dermatology	213	126	139	73	551
Diabetic Medicine	95	49	22	31	197
ENT	225	88	73	126	512
Endocrinology	73	49	23	2	147
Gastroenterology	28	17	20	24	89
General Medicine	1	5	0	0	6
Geriatric Medicine	10	5	0	0	15
Gynaecology	86	13	2	3	104
Medical Oncology	0	0	0	1	1
Nephrology	29	0	0	0	29
Neurology	84	27	34	16	161
Ophthalmology	1672	708	956	950	4286
Oral Surgery	118	38	14	30	200
Orthodontics	69	30	33	0	132
Orthoptics	347	119	42	0	508
Paediatrics	256	128	115	131	630
Pain Management	77	16	0	18	111
Plastic Surgery	48	43	52	32	175
Podiatry	0	0	0	0	0
Respiratory Medicine	98	81	113	81	373
Restorative Dentistry	9	4	0	0	13
Rheumatology	348	237	301	411	1297
Thoracic Surgery	0	0	0	0	0
Trauma & Orthopaedics	50	5	5	0	60
Upper Gastrointestinal Surgery	13	8	19	17	57
Urology	63	32	35	53	183
Vascular Surgery	2	1	0	0	3
Total	4536	1927	2072	2083	10618

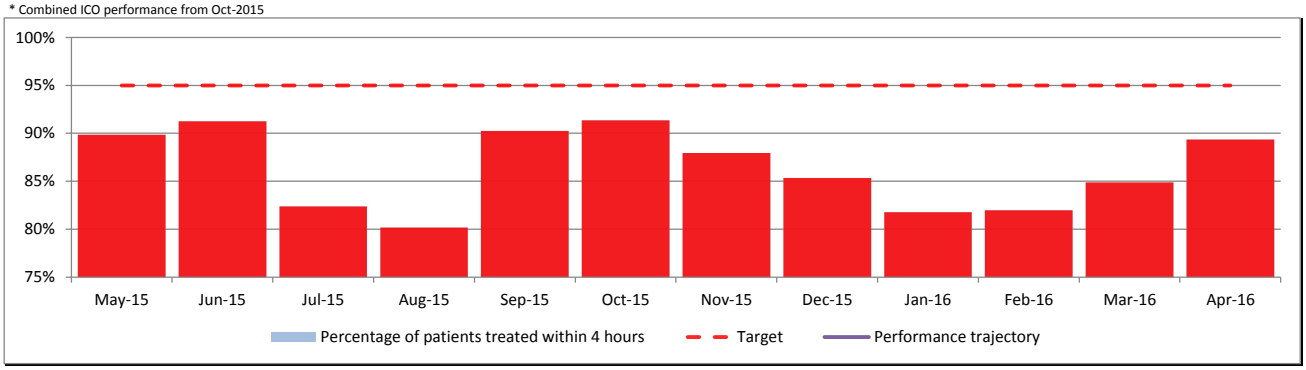
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
0-6 weeks	3781	4105	4211	4068	3886	3794	3556	4195	4500	3929	4488	4536
6-12 weeks	1274	1337	1511	1593	1771	1589	1546	1697	1685	1584	1864	1927
12-18 weeks	1196	1344	1420	1761	1778	1754	1608	1836	1924	1689	1889	2072
18 weeks +	1107	1064	1089	1216	1324	1388	1388	1557	1682	1665	1979	2083
6 weeks +	3577	3745	4020	4570	4873	4731	4542	5090	5291	4938	5732	6082



Time spent in A&E

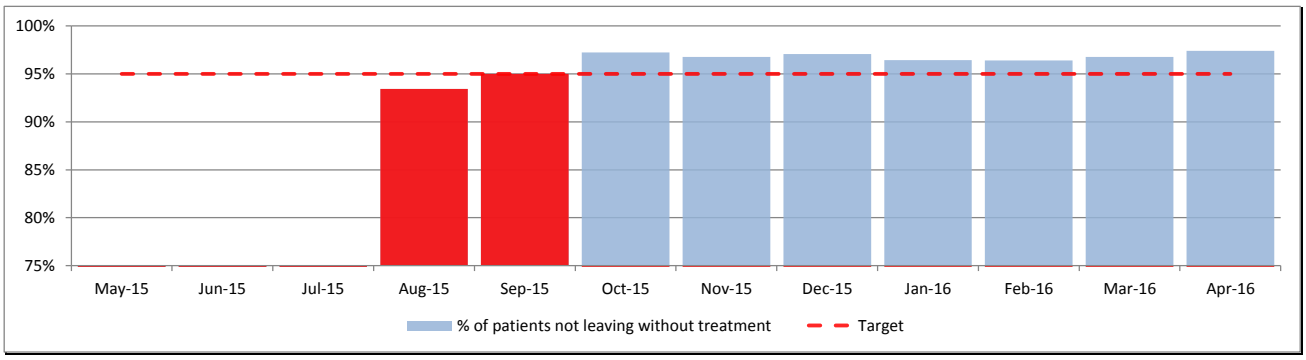
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E attendances	6646	6518	6755	6209	6087	8712	8451	8135	8223	8084	9298	8627
Visit time > 4hours	674	571	1192	1232	594	753	1020	1192	1500	1459	1406	919
Percentage of patients treated within 4 hours	90%	91%	82%	80%	90%	91%	88%	85%	82%	82%	85%	89%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Performance trajectory												85%

* Combined ICO performance from Oct-2015



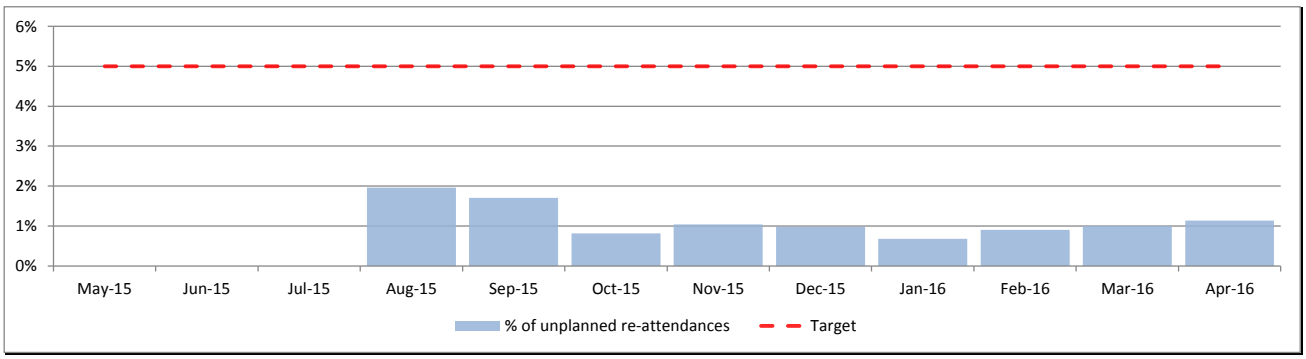
Left department without being treated -Type 1 only

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E attendances				6209	6087	8712	8451	8135	8223	8084	9298	8627
Patients left without being seen				408	305	241	272	239	294	291	299	223
% of patients not leaving without treatment	#DIV/0!	#DIV/0!	#DIV/0!	93%	95%	97%	97%	97%	96%	96%	97%	97%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



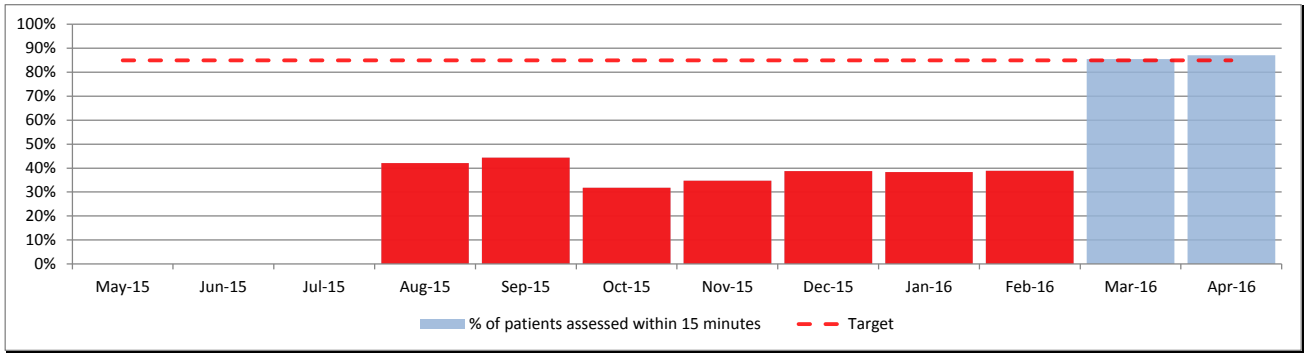
Unplanned re-attendances

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E attendances				6209	6087	8712	8451	8135	8223	8084	9298	8627
Re-attendances				122	104	71	88	80	56	73	93	98
% of unplanned re-attendances	#DIV/0!	#DIV/0!	#DIV/0!	2%	2%	1%	1%	1%	1%	1%	1%	1%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%



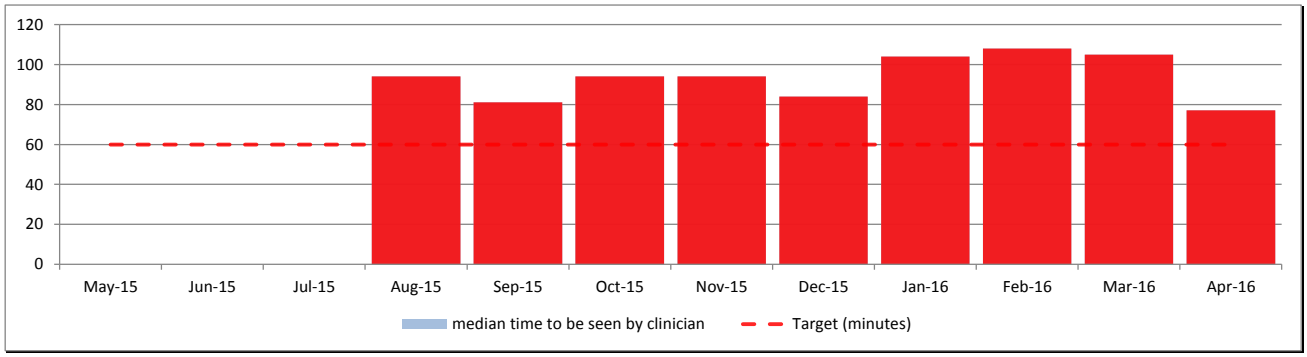
15 minutes to first assessment

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E attendances				6209	6087	8712	8451	8135	8223	8084	9298	8627
% of patients assessed within 15 minutes				42%	44%	32%	35%	39%	38%	39%	**85%**	**87%**
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



Median time to be seen by clinician

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
A&E attendances				42217	42248	42278	42309	42339	42370	42401	42430	42461
median time to be seen by clinician				**94**	**81**	**94**	**94**	**84**	**104**	**108**	**105**	**77**
Target (minutes)	60	60	60	60	60	60	60	60	60	60	60	60



Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25/5/16
Title:	Annual Infection Prevention & Control Report 2015/16 and Annual Plan 2016/17
Lead Director:	Jane Viner
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The Annual Director of Infection Prevention and Control (DIPC) report provides a comprehensive review of the infection control performance against key targets and standards over the year. It also provides the Infection Prevention and Control Committee priorities for 2016/17NHS England compliance targets for the coming year are unchanged:

MRSA - to report zero cases.
CDiff - to report less than 18 cases associated with a lapse in care

Key Issues/Risks

Performance 2015/16:
The Trust reported 3 MRSA bacteraemias (one was a collection contaminant) from 1/4/15 to 31/3/16.
There was a 38% reduction in MSSA bacteraemias compared with the previous year.

The Trust reported 27 acute Trust, *Clostridium difficile* (*C difficile*). 11 patients were defined as a 'lapse in care' against a contractual target of 18 'lapses in care', however only two 'lapses in care' could have predisposed the patients to *C difficile* infections.

For the community hospitals, there was zero MRSA and there was 1*C difficile* lapse in care against a target of 4.

The incidence of acute Trust *C difficile* has increased this year but the total numbers and percentage of patients that acquitted *C difficile* after a hospital in-patient episode has reduced.

The Team structure is a key issue due to two retirements and the two members of staff returning to work part time, two further retirements are due in the next couple of years. The team having both a community and a hospital lead is challenging and under review. The DIPC and Chief Nurse are reviewing the IP&C leadership structure with HR support.

The annual deep clean was not completed due to high bed occupancy and the loss of a decant ward to a substantive ward. This has been discussed at the Infection Prevention and Control Committee and flagged to the Operations Lead as a significant risk. There is an association between levels of environmental cleanliness and the incidence of *Clostridium difficile* infections.

High Bed Occupancy means that:

1. Risk assessment of side room use is critical to ensure these rooms are allocated appropriately.
2. In the Emergency Department, cubicles may be designated for patients to stay overnight.
3. Locating medical outliers on surgical wards could put post-operative patients at risk of MRSA wound infections.
4. It may not be possible to undertake the hydrogen peroxide vapour treatment in side rooms.

It is recommended that the planned six month review of the Infection Control Team structure and function is completed and reported back to the Quality Assurance Committee .

The annual deep clean program will be reviewed to explore the possibility of a two year cycle of bay by bay deep cleaning. The Quality Improvement Group will monitor delivery of the plan and report variance to the Quality Assurance Committee.

Recommendations:

That the Board consider the assurances contained in this Report and consider if further action is required

Summary of ED Challenge/Discussion:

During 2015/16 Warrington ward was available to relocate other wards and enable those wards to be deep cleaned. The loss of Warrington as a decant ward will impact on the deep clean schedule. The operations team are developing a plan to facilitate the deep clean schedule for 2016/17 and alternatives to full ward decant will be explored.

This risk to effective infection control created by the loss of a decant ward is managed as the Trust spends comparatively more than other organisations on a comprehensive reactive deep cleaning service which includes hydrogen peroxide decontamination treatment. This is to avoid and shorten any costly and operationally difficult closure of clinical areas for infection control purposes. The criteria that determine the necessity and frequency of rapid response cleans will be reviewed by the Clinical Environment and Infrastructure Group and the Infection Prevention and Control Committee.

The peer inspection undertaken by Dr Nizam Damani in January 2016 provided areas for focus. These are included in the IP&C annual work plan.

Ensuring the effective use of side rooms is a key challenge. The daily side room status report implemented in February 2016 provides an accurate and timely status report to inform decisions but the demand for side rooms currently exceeds capacity. The lack of side rooms for isolation is included as a priority in the Trust Estates plan.

Internal/External Engagement including Public, Patient and Governor Involvement:

The CCG and Public Health England are members of the Infection Prevention and Control Committee. There is a Governor member and a designated NED.

Equality and Diversity Implications:

None

Torbay and South Devon NHS
NHS Foundation Trust

V 18.5.16

Infection Prevention & Control Annual Report 2015/16

And Annual Plan 2016/17

S Hoque DIPC
L Kelly Lead IPCN Hospitals
N Trigg Lead IPCN Community

Ratified Infection Prevention and Control Committee
Board date June 2016

Contents

Summary

The Infection Prevention and Control Team (IPCT) of Torbay and South Devon NHS Foundation Trust (TSDFT) continue to prevent infection through the whole patient journey (Terms of Reference Appendix1).
Before October 2015 the Committee reported directly to Workstream 1 – Patient Safety and minutes to Workstream 5. After the ICO in October 2015 the Committee reports to the Quality Improvement Group (QIG) and this in turn reports to the Quality Assurance Committee (QAC).
From 1/1/2016 the community based and the acute hospital IPCTs merged to a single team on a single site accountable to the Chief Nurse (CN) and to a single Director of Infection Prevention & Control (DIPC) - a Consultant microbiologist at Torbay hospital.

The Trust reported 3 MRSA bacteraemias (one was a collection contaminant) from 1/4/15 to 31/3/16 and the Trust target was zero. But there was a corresponding 38% reduction in MSSA bacteraemias compared with the previous year.
The Trust reported 27 acute trust, attributable *Clostridium difficile* (*C difficile*) and 11 patients defined as a 'lapse in care' (https://www.england.nhs.uk/patientsafety/associated-infections/clostridium-difficile/) against a contractual target of 18 'lapses in care', however only two 'lapses in care' could have predisposed the patients to *C difficile* infections.

The CEO invited an External Peer Reviewer – Dr Nizam Damani (Senior Consultant Advisor Infection Prevention & Control & Microbiology World Health Organization, Geneva, Switzerland) – to the trust to review the *C difficile* controls at TSDFT, in January 2016, and 20 recommendations were made against which the IP&C Team have set an action plan.

1. Introduction

The aim of this report is to give assurance of infection, prevention and control and to report the performance of the IPCT to the Trust board, patients, staff, public and Commissioners it also sets out the next annual plan of the IPCT.
The IPCT consists of the DIPC- 6 sessions a week
Acute hospital based
Band 8a
1.0 band 7 acting up 0.8 WTE funding
1.0 band 6 job share retire and return
1.0 band 6 acting up
1.0 band 5 vacancy
Community based
1.0 band 8a
1.0 band 6
1.0 band 4

2. External Peer Review

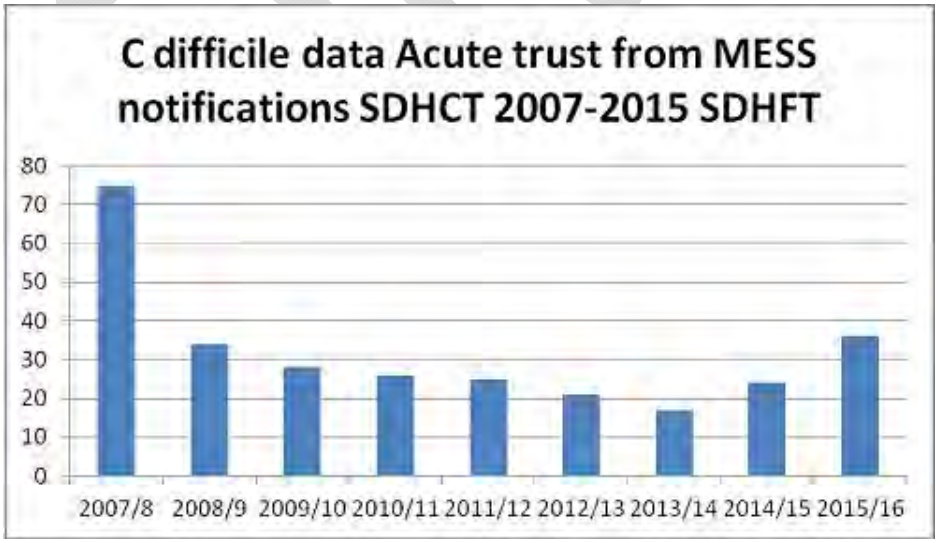
The External Peer Review occurred because the numbers of patients with healthcare acquired *C. difficile* infections increased from May15- July15 to 11 patients (simultaneously with the ward closures due to Norovirus).
Key recommendations were:

- Consider a permanent DIPC post instead of the current rotational post
- Regular DIPC meetings with the CEO with a standardised reporting proforma
- Deputy Director of Nursing to assist the CN but not have the IPCT accountable
- A clinically focused Working group to support the IP&C Committee
- A consideration for an out-of-hours IP&C nursing cover
- Antimicrobial programme needs to be expanded to audit compliance with guidelines and appropriateness of antimicrobial prescribing (for full Action Plan see Appendix 2).

3. *Clostridium difficile*

Targets for C. difficile:
The South Devon and Torbay CCG set the *C. difficile* toxin positive (CDT+) target measured EIA, for SDHFT, at no more than 18 'lapses in care' from 1/4/15 to 31/3/16. Torbay hospital had 11 'lapses in care'. For the Community hospitals an internal target of 4 'lapses in care' was set and there was 1 'lapse in care'.
C. difficile has increased for TSDFT from 2013/14 and a review of the risk variables were made by IP&C – see below:

- The number of stools sent for testing and antibiotic usage is fairly static
- There is an increase in admissions of patients 75-85 years
- The trust's Deep Cleaning Team moved to Tristel™ from Atcichlor Plus™. This latter is under review.



Benchmarking in the SW

Three CCGs, SD&T, Kernow and Dorset, reported incidence of non trust apportioned cases of CDI that were significantly higher than the national average for this quarter (Q3 2015/16).

These 3 CCGs and also Bath and NE Somerset CCG also reported an incidence of total cases of CDI that was significantly higher than the national average for this quarter. The incidence of non trust apportioned cases and the total cases of CDI for STD CCG was also significantly higher than the national average to the 99% upper control limit.

Action from TSDFT

The above results from PHE are not age-adjusted.

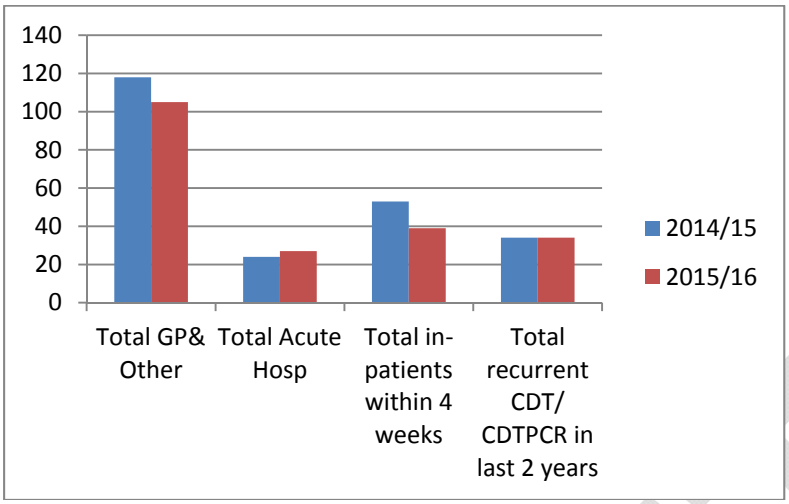
For the SDTCCG, from March16, the Pathology Dept'. at TSDFT Email the GP Practice manager every single positive C diff toxin and C diff PCR result with an accompanying Patient Information Leaflet and a treatment plan for C diff to go in the patient's record. This means recurrences can be treated rapidly with an escalated protocol. We have also introduced a Faecal Microbiota Transplant Service at Torbay hospital to assist with treating recurrences.

C. difficile outbreak

There has been one *C. difficile* outbreak this year, as defined by DH, two patients with the same type of *C.difficile* within 28 days in a single ward. This was on Cheetham Hill ward in bay A were a there was a delay in decontaminating the affected bay with hydrogen peroxide vapour (HPV). This was due to bed pressures because of the simultaneous increase in seasonal influenza and Norovirus in March 2016.
Also, Simpson ward did have 3 patients with C difficile in September and an Outbreak Meeting was convened immediately and prior to the typing results. An action plan was developed and followed up at the Infection Prevention & Control Committee. Subsequent typing results showed that this was not an outbreak. Actions, taken from the root cause analyses (RCAs), that were not completed, such as increasing the numbers of side rooms, has been carried forward.

C. difficile – compared with the previous year.
Although acute hospital CDT has increased this year, the total numbers & percentage of patients, that acquired CDT after a hospital in-pt stay, has reduced which could be due to an improvement in IP&C.

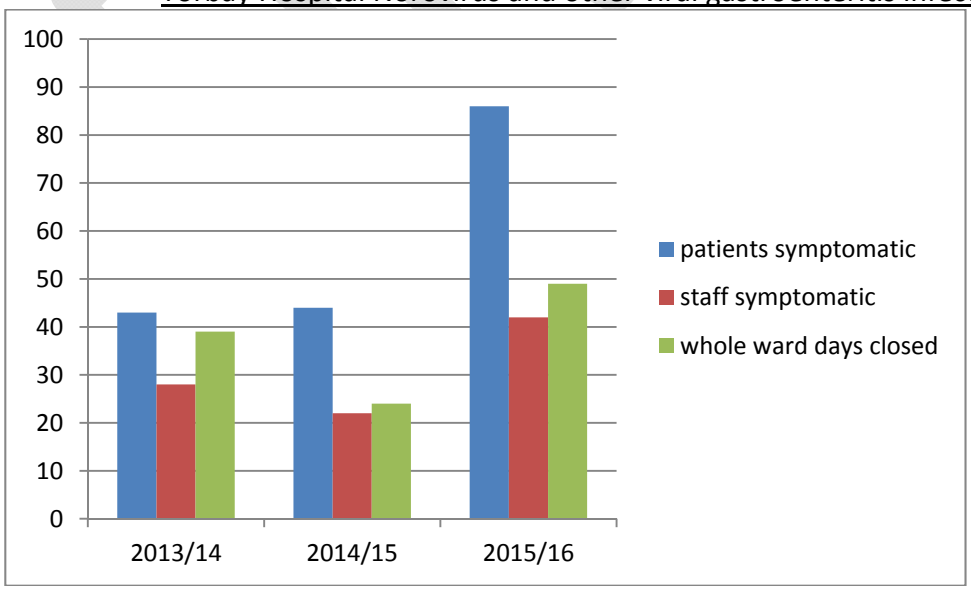
CDT 2015/16 compared with 2014/15



4. Norovirus and other viral gastroenteritis

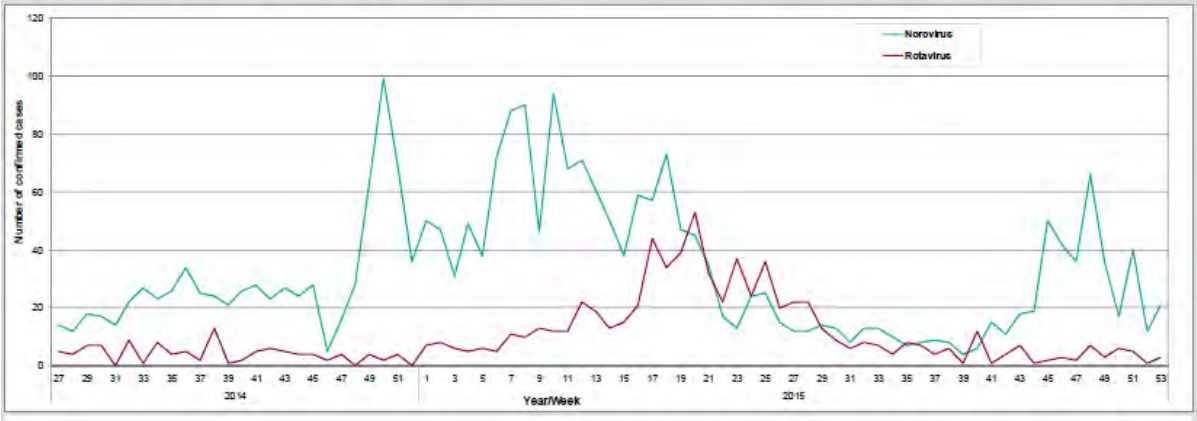
Much of the Infection Control work to control Norovirus overlaps with that of CDT+ control. From May 2015 to July 2015 there were 8 ward closures at Torbay hospital, although this is more than previous years it correlates with epidemiology for the rest of the SW (see PHE graph below). In the Community hospitals there were 5 ward closures.
Overall the KPI of ward closures for no more than 12 days was maintained.

Torbay Hospital Norovirus and other viral gastroenteritis infections



LABORATORY CONFIRMED CASES

Figure 1: Weekly laboratory reports of norovirus and rotavirus, PHE South West, 2014 week 27 to 2015 week 53
Source: PHE Second Generation Surveillance System (SGSS)*†



RCA investigations from the RCAs on ward closure due to Norovirus 2014-16 :
Number or RCAs completed were 5 and the themes were:

- Incorrect documentation of Diarrhoea and Vomiting Risk Assessment, whether due to omission or printing Symphony outputs prior to on-line completion.
- Bed occupancy so that side rooms could not be vacated to put symptomatic patients in or on some wards insufficient side rooms.

Actions from Norovirus RCAs and Outbreak Meetings completed:

Better communication from Nursing / Residential Homes, Schools and Nurseries regarding Norovirus; **LA** Lead Torbay & PH consultant to issue letters to care homes, in September, on how to notify suspected Norovirus.	IP&C PHE	Sept 2015 complete
Prompt reporting of outbreaks to PHE from Nursing/Residential Home, schools and nurseries.	IP&C PHE	Sept 2015 complete
IP&C member and head of operations to attend a forum for Nursing Homes	IP&C PHE	Sept 2015 complete
Services in Trust could be used to help sufferers in their own home.	*IP&C* *MAT/ GP*	*Sept 2015* *complete*
Education to Flow Team in placement of patients, accurate recording on green risk assessment form.	*IP&C* *Operations* *ED/ EAUs*	*Sept 2015* *complete*
Send reminders to A&E, EAUs, wards, importance of accuracy of the Diarrhoea and Vomiting Green Risk Assessment Form.	*IP&C* *ED/ EAUs*	*Sept 2015* *complete*
Amend Management outbreak viral Diar'+/or Vom' CG0653; **M**atrons to gather information and update IC on outbreaks on their wards prior to Control Meetings **E**mail to Radiology / AHPs stating that diagnostic procedures and care must continue and advise on IP&C precautions. **C**reate clean environment for home owners/assessors to enable so assessing patients allowing them to be discharged safely. **S**idney 2012 strain of Norovirus can give a false negative result. **O**nly permanent staff with prolonged patient contact need to change into scrubs.	*IP&C*	*Sept 2015* *complete*
Update Outbreak Control plan 0761 incorporating:- **L**ist of people required at Outbreak Meetings. '**N**orovirus Enhanced Activity Meeting', is called when increased activity in the	*IP&C*	*Sept 2015* *complete*

community/ Trusts, bay closures > 2 wards. '**N**orovirus Outbreak Meeting', when 2 wards are closed within 5 working days of each other. **D**IPC/ Acting Deputy DIPC is in charge of the Enhanced Activity Meeting or Outbreak. **M**inutes/Actions from Enhanced Activity /Outbreak Meetings are sent to affected wards managers & actioned. **C**hecklist on what should be done when an outbreak is called & include AHPs saying that they are able to go onto closed wards. **D**istribution list of ward closures & O/B minutes- Tissue Viability & M Electronics - shortage/cleaning pressure relieving mattres'.		
Education for Stores staff to ensure they go on closed wards to be arranged. DIPC to discuss with Mark Slaney.	*DIPC*	*Sept 2015 complete*
Second deprox machine being purchased plan a 24 hour service. **C**ommunity Hospitals will have 12hr cover from 07:30 – 19:30.	*Hotel Services*	*Sept 2015 complete*
Remind staff when admissions from care homes; contact the care home to see if they have any outbreaks of D&V.	*IP&C* *ED/ EAUs*	*Sept 2015 complete*
Costs of Warrington ward/ EAU ICE cubes and update them by contacting Bioquell – then present the costs to Ops Lead.	*Estates* *Ops*	*Sept 2015 complete*
Shortage of scrubs and variety of sizes – contact Sunlight to standardize batches and package labeling.	*Hotel Services*	*Oct 2015 complete*
Stop shortage of Furniture/Equipment-Elizabeth, Warrington	*Operations*	*Dec 2015*
Private changing areas for scrubs –ward managers create areas with laminated posters & SOPs, as part of contingency planning.	*Ward Managers*	*Nov2015 complete*

Actions not completed from Norovirus RCAs:

- Increased numbers of EAU and Ainslie ward siderooms – currently with Capital Projects Phase I & II.
- Hetherington block offices share kitchens and toilet facilities with wards – currently with Capital Projects Phase I & II.
- Hetherington block need 4 bedded bays with en-suite bathrooms and doors to each bay and more side rooms – currently on Risk Register.

5. MRSA & Meticillin Sensitive Staph. aureus (MSSA) bacteraemias

There have been 3, TSDFT acquired, MRSA bacteraemias (full details in Section 15, SIRI) and DH's zero tolerance was breached. The root cause analyses (RCAs) concluded that:

- An end-stage, osteosarcoma patient with both soft tissue and peripherally inserted central venous catheter (PICC) as possible sources. Now Bank/Agency staff are forbidden from accessing PICCs on Turner ward. This may prevent further PICC infections in future.
- An alcoholic liver disease patient with enteropathy the possible source. It is not known whether decolonisation of the patient's MRSA at an earlier stage would have prevented the infection.
- A collection contaminant from a collapsed baby requiring a cut-down through cradle cap in resus. This was deemed an unavoidable contamination and the resus was successful.

There have been 8, TSDFT acquired, MSSA bacteraemias and KPI of a 5% reduction compared with last year was attained. The root cause analyses (RCAs) concluded that the sources were:

- 2 with hospital acquired pneumonia (HAP), not ICU.
- 2 with aspiration pneumonia, not ICU.
- 1 PICC
- 1 periprosthetic fracture infection (no blood cultures taken on admission)
- 1 unknown

It is possible that the patients with HAP and aspiration could have been avoided but the full nursing detail is not available (eg. nursed at 35 degree angle, etc). The PICC infection was both MSSA and E.coli in a very immunosuppressed patient so may not have been avoidable.

6. *E. coli* bacteraemias & ESBLs

The rate of extended beta lacatamase (ESBL) producing E.coli bacteria in blood cultures is monitored and guides empirical antibiotic guidelines because ESBLs are one of the markers of antibiotic resistance in bacteria.

Results of ESBL producing E.coli in blood and urine from 2012 to 2015 in both Acute trust and Community.

	2012/13	2013/14 (6 months data)	2014/15 (6 months data)	2015/16
ESBL rate in blood cultures	14%	0%	4% (0% acute trust)	4.4% (7.9% acute hospital)
ESBL rate in urine samples	5%	4%	not done	not done

In 2015/16 there were 24, TSDFT acquired, E.coli bacteraemias and case note review, revealed the causes listed below:

Presumed source E.coli bacteraemia	Number of bacteraemias	Comment
Immunosuppressed patients	7	1 PICC, 3 perianal infection, 1 biliary stent, 2 urinary tract infection, 1 unknown.
Peripheral cannulae	0	
Urinary catheter associated	5	Of these actions required after 2 reviews one on Ainslie to treat sepsis earlier and fedback to T&O Clinical Staff at a 'Pearl of Wisdom' Teaching Session. The other was urinary catheter care documentation on Warrington ward.
Urinary tract infection (no catheter)	2	
Gastro-intestinal related	4	most patients had end stage malignancies
Unknown	5	3 casenote reviews outstanding

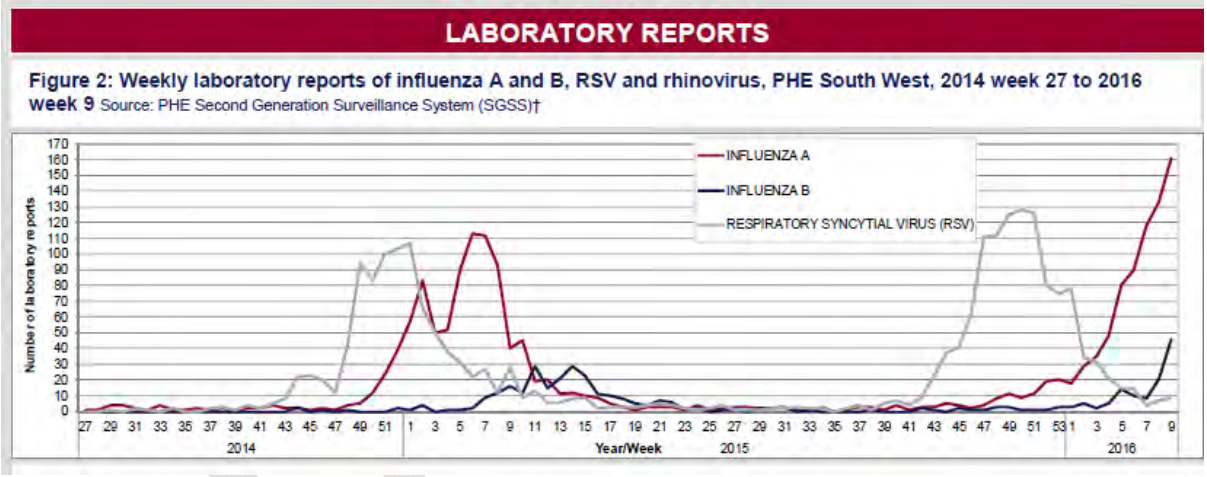
The KPI of a 5% reduction in E.coli bacteraemias was not attained (23 E coli bacteraemias in 2014/15), This may be due to the increased number of patients treated with acute myeloid leukaemia in 2015.

7. Seasonal Influenza

The seasonal influenza arrived in the SW in March which is late and was worse than last year it was predominantly Influenza A type H1N1. The respiratory ward was closed for a few days, in March, to allow isolation of flu patients and a separate isolation of flu contacts. The Microbiology laboratory tested about 20 patients a day during March. The IP&CT will introduce a new Seasonal Influenza Guideline for the trust intranet and it will contain a section for Intermediate Care. We will introduce;

- distribution of seasonal influenza policy/ guideline and the seasonal influenza PPE posters to all managers at the same time as influenza vaccination reminders in September /October,
- allocate responsibilities for FFP3 mask fit testing to clinical area managers,
- the PHE guidance on influenza treatment and prophylaxis will be sent to the MD for distribution to clinical staff at the start of the influenza season, rather than the CDs.

The PHE data for the SW is given below.



8. Performance of Infection Control against Infection Control Key Performance Indicators 2015/16

This is not a comprehensive list of all the Actions because each KPI represents at least 10 actions to be completed.

Joint Annual Programme of Work 2014/15 TSDFT:		Action/ Leads	Planned Completion date	RAG rating & date made
i MRSA Control & MRSA /MSSA bacteraemia control	**KPI one– stay within CCG / Monitor Ambitions for MRSA bacteraemia (none)**	**DIPC**	**March 2016**	**Red= 3**
	KPI two- Reduce MSSA bacteraemias by 5% (no more than 12)	**DIPC**	**March 2016**	**Green total=8**
ii C.difficile control & Norovirus outbreaks	**KPI three – stay within CCG / Monitor Ambitions for *C. difficile*** Total Number of 'Lapses In Care', is compliant at less than 18.	**All ICNs & DIPC**	**March 2016**	**Green lapse in care =10**
	KPI four – No ward closures due to Norovirus for > 14 days.	**All ICNs & DIPC**	**March 2016**	**Green**
iii Urinary catheter care/ESBLs/ E. coli bacteraemias	**KPI five - Reduce E coli bacteraemias by 5% in SDHFT (no more than 22).**	**All ICNs & DIPC**	**March 2016**	**Red total =25**

Not achieving the KPI for *C. difficile* was because of more admissions with CDT and an increase in recurrence rates so guidelines for Faecal Microbiota Transplants will be introduced as well as GP specific algorithms on managing *C. difficile*.

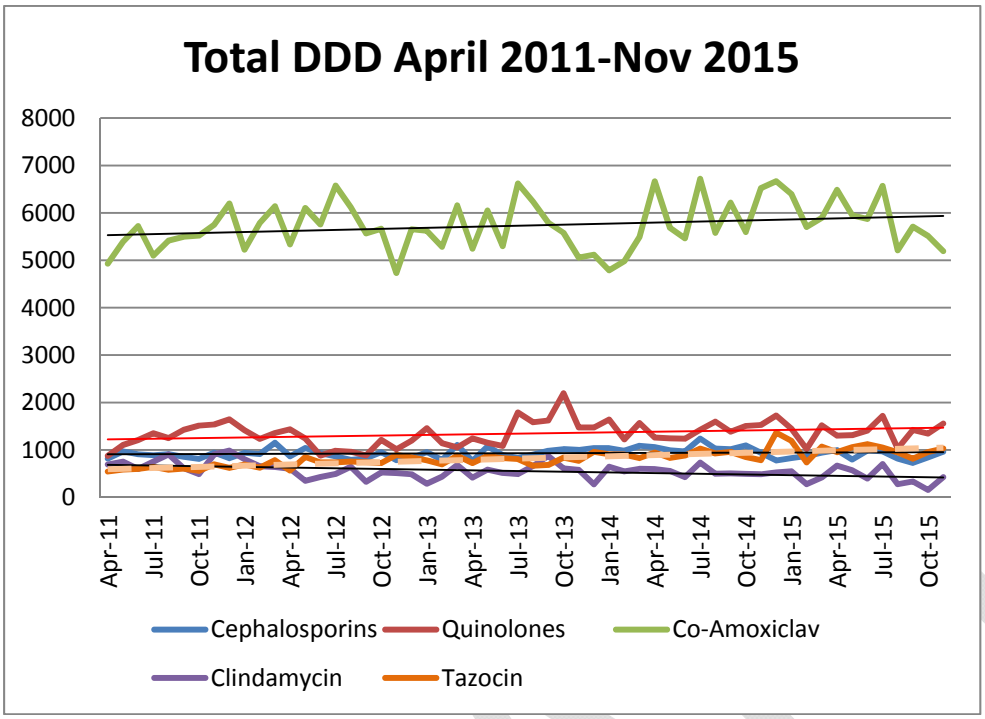
9. Antimicrobial Report

The Antimicrobial Team (AMT) provides Antimicrobial Stewardship throughout the Trust and the prescribing policy is documented in CG1098. Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) and paediatrics (CG1118) on the trust intranet site and the Apple and Android App.

The AMT consists of the Antimicrobial Pharmacist and Consultant Microbiologist. The Antimicrobial Pharmacist has left the trust in October 2014 and an appointment of a trainee was made in February 2015.

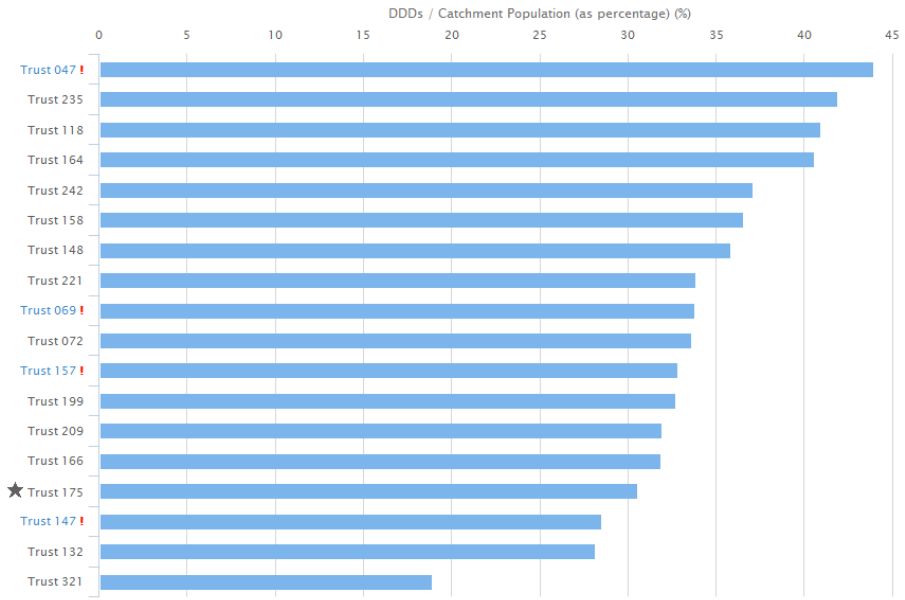
Antimicrobial consumption is measured by Defined Daily Dosage (DDD) which means we can divide the total consumption of antibiotic used by the standard denominator of normal

dosage for a day for a normal person or DDD. It can be seen over time that co-amoxiclav use has increased but clindamycin use has decreased, both these are associated with C. difficile.

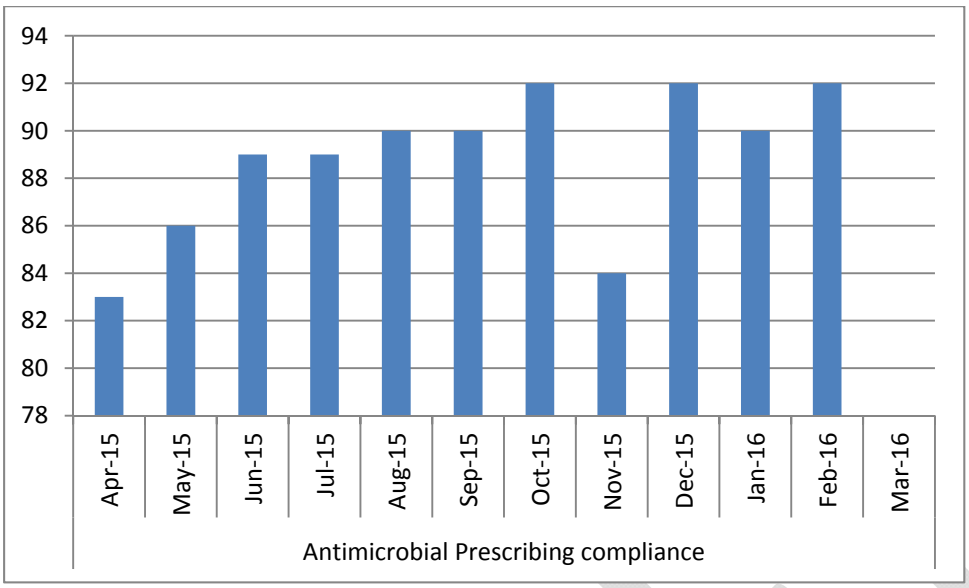


Antimicrobial consumption can be benchmarked against the hospitals registered with RX Info (http://10.151.162.18/). In the graph below it can be seen that TSDFT is trust numbered 175 and has low intravenous antimicrobial consumption due to good antimicrobial stewardship.

Abx IVs - All Antimicrobial - all IV preparations and IM benzylpenicillin. As DDDs (used in hospitals or with MAT team) per Catchment population c/w 17 other trusts (accessed 22/2/16)



The AMT performs, and feeds back results to ward teams, the monthly Antimicrobial audits (Torbay hospital results are below).



The reduced compliance in November was partly due to poor compliance on the Stroke ward, the Lead Stroke Consultant incorporated Antimicrobial Stewardship in the junior Dr Stroke Induction package.

Below are the bi-annual results for the Community hospitals and from April 2016 these will also be completed monthly.

Action Plan for Community hospital – Saving Lives Antimicrobials -performed August 2015

Community Hospital	Q2	Findings	Actions
Ashburton	78%	Only 2 patients audited. Neither had indication documented on the drug chart.	1. Check which GP practice 2. Email feedback to practice
Bovey Tracey	100%	3 patients audited. Compliant with all audit criteria.	No action required.
Brixham	83%	6 patients audited. Indication only documented on the chart for 2 patients and no cultures taken for 1 patient.	Feedback results to Greenwood, Compass House and St Lukes GPs
Dartmouth	90%	4 patients audited. Indication not documented on the chart for 2 patients.	No action required.
Dawlish	N/A	No patients on antibiotics	
Newton Abbot Teign	79%	3 patients audited. None had indication documented on drug chart.	Feedback results
Newton Abbot Templar	70%	4 patients audited. No cultures for 1 patient, no duration documented for 2 patients and no indication documented for 2.	Feedback results

Paignton	75%	6 patients audited. No cultures for 1 patient, no duration documented for 1 patient and no indication documented on the chart for 5 patients.	1.Find out which doctors cover the hospital 2. Feedback results to the relevant doctors.
Teignmouth		No results received for Q2	1. Find out which pharmacist & Ensure the audit is undertaken
Totnes	100%	Only 1 patient audited. Compliant	No action required.

10. Decontamination

The monthly Decontamination Group Meeting chaired by the Decontamination Lead provides assurance on compliance with the trust's decontamination policies and National policies and best practice guidance.

With the ICO there is an extra decontamination unit in Castle Circus and assurances have been obtained from the Lead Dentist managing the unit.

The Tristel™ Sporicidal wipe system for non-lumen probes used on mucosal surfaces requires a re-audit in October 2016. There have been no issues with automated endoscope disinfectors nor the large porous load sterilizers or Instrument washer disinfectors.

11. Estates & Cleaning

Areas Refurbished
Estates has refurbished Midgley ward, parts of Cheetham Hill ward, Labour ward but A&E remains outstanding.
Infection, Prevention and Control were consulted on Capital Projects- Linnac, Oncology East and the ongoing CCU.

Cleaning
The PLACE inspection was good for ward cleanliness, hand hygiene and equipment cleanliness.
Enhanced Cleaning is present in the following areas;
ICU, Turner, Cromie, Allerton (gastroenterology admissions and surgical 'EAU-type' admissions).
Over a 1,000 extra 'Cleans' including 'Deep Cleans' have been requested by the IP&CT and delivered by the Estate's Cleaning Team and this has enabled wards and ward bays to re-open quickly after diarrhoeal disease and goes someway to mitigating the lack of siderooms in the trust.
Annual Deep Clean RAG Rating for 2015/16 shows only 57% compliance and this has been mainly due to access restrictions due to bed pressures and conversion of the decanting ward Warrington to a substantive ward.

Because of litigation issues over the use of ActichlorPlus in 2013, the trust introduced Tristel™ (chlorine dioxide) as a cleaning product to replace Actichlor Plus and the Tristel™ manufacturer's literature states that Tristel™ kills *C. difficile* spores at the routine concentration used. However, since the introduction of Tristel™ in May 2013 the C. difficile

rate has increased (see graph below). The Hotel Services & IP&CT are exploring alternatives such as chlorine releasing wipes at 1,000ppm for high frequency touch surfaces and detergent for floors.

HCAI Quarterly Report from PHE QMRL data

The Deep Cleaning Team commenced using Tristel May 2013

Waste

The IP&CT have advised on the standardisation of waste collection bags throughout the trust and this includes the introduction of orange waste bags instead of yellow bags in theatres with tiger bags to be used for non-infectious cases in theatre recoveries.
The IP&C Committee have tabled a request for the Health & Safety Lead to set up a trust 'Sharps' Working Group.

12. Water Safety

Water Systems Management Group

This group meets every two months to review water safety and ensure compliance with HBN 01-04 including recent updates on Pseudomonas control. The Legionella water test results are reviewed as well as the flushing logs. The Community hospitals will have the flushing logs audited monthly by the Matrons, from March 2016.

Pseudomonas testing of augmented care areas twice yearly did not reveal positive sites.

Legionella pneumophila has not been isolated.
Torbay hospital uses heat to control Legionella and in addition to most trusts has a copper/ silver ion system in place but there have been issues with the latter and it has been off-line. The trust will no longer be using Records for Buildings (on which the 2014 Legionella Risk Assessment is logged)and instead plans to use 'MICAD' to log the work against the 2014 Legionella Risk Assessment. But in the meantime the unsupported 'WCS Shires' system is being used by Estates.

Progress against the Legionella Risk Assessments and the flushing non-compliances are reviewed at the IP&C Committee and in general compliance has improved over the year as systems have been put in place to cover Domestic staff annual leave.

13. Critical Ventilation including Theatre Ventilation compliance with both Appendix 1 & 2 HTM 03-01 part b Operational Management.

Critical ventilation is required to prevent healthcare acquired infection and is a vital part of patient safety.
Ultra clean air theatres require engineering checks twice a year and all other specialist ventilation require annual engineering checks. All areas have passed except for the main ICU because it cannot be accessed (but the side rooms can) and Recovery. The Aseptic suite, level 2 suite report was not received by IP&C due to access being unavailable. Any remedial work identified by the Critical Ventilation Reports are placed on an Action Plan within Estates and reviewed at the IP&C Committee. Responsibility for Critical Ventilation is now with the Mechanical Services Manager in the Estates Department.

14. Surveillance, Audits & Education

Infection Prevention Society (IPS) Audits
These are performed every 2 years and the results for Torbay hospital are listed in Appendix 4. The areas requiring the most input are A&E and George Earle ward. The action plans are sent to ADNs, Matron and Managers as well Estates and Hotel Services. Completed and outstanding actions are reviewed at the Patient Environment Group chaired by the Head of Facilities. The Community hospitals will be re-audited as the pre-ICO tool used was different.

Laboratory~Ward based Deep Surgical Site Infection (SSI) rates for Prosthetic Orthopaedic Surgery from April 2012 to Sept 2015.
For April to September 2015, the post-op infection rates for total hip replacements (THR), total knee replacements (TKR) and Hemi-arthroplasties are all very close to the national average (See table) and all actions set last year have been completed.

This year surgeons were consulted by the T&O CD and felt that this rise in infection since 2010 was materially induced by the change to the thromboprophylaxis regime to Fragmin/Dabigatran in 2010. This was the only change to practice occurring at this time. They are in discussions to revert to Fragmin/Aspirin for standard risk Arthroplasty patients.

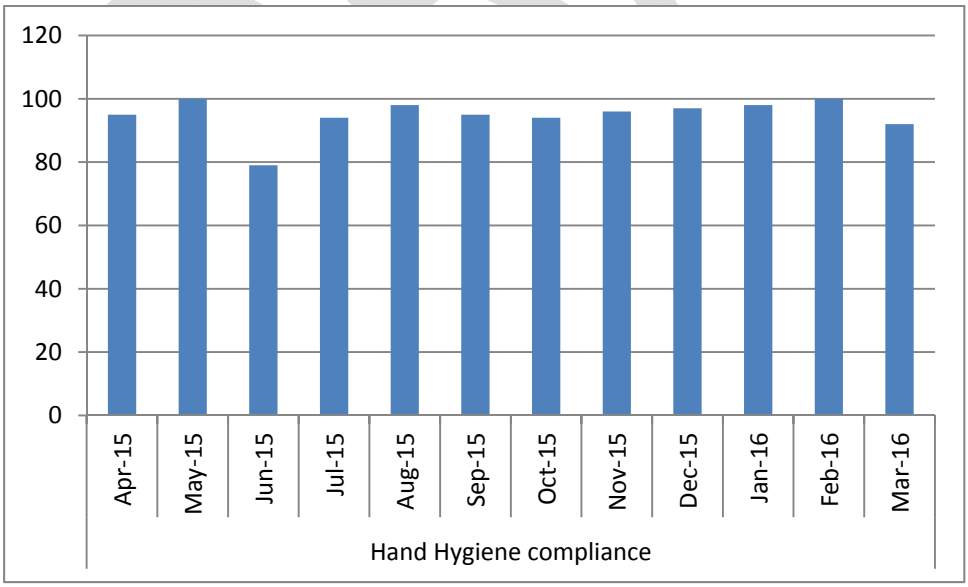
	THR infections	THR infection rate	TKR infections	TKR Infection rate	Hemi-arthroplasty infections	Hemi-arthroplasty infection rate
April-Sept 2012	5 infections (Risk scores 2,2,0,0,1)	169 ops **rate=3%**	4 infections (Risk score all=0)	144 ops **rate =2.8%** (if exclude the Grp A strep=2.1%)	4 infections (Risk score all=1)	98 ops **rate= 4.1%**
Oct 2012-March 2013	1 infection (Risk score ?)	184 ops **rate = 0.5%**	4 infections (Risk score three at 0 , one at 1)	137 ops rate = **2.9%**	1 infection (Risk score 1)	101 ops **rate=1%**

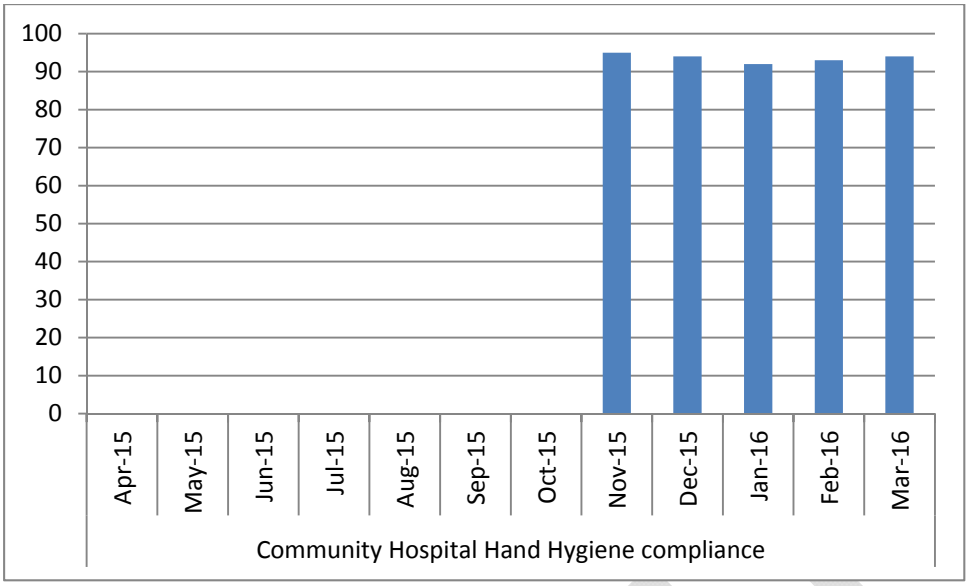
April-Sept 2013	1 infection (Risk score 1)	173 ops **rate = 0.6%**	5 infections (Risk scores 0,1,2,2,1)	127 ops **rate = 3.9%**	1 infection (Risk score 1)	109 ops **rate=0.9%**
Oct 2013 – March 2014	2 infections (Risk score 1)	164 ops **rate = 1.2%**	4 infections (Risk scores 1,1,1,0)	166 ops **rate = 2.4%**	0 infections	109 ops **rate = 0%**
April-Sept 2014	1 infection (Risk score 2)	230 ops **rate= 0.4%**	3 infections (Risk scores 1,1,1)	216 ops **rate=1.4%**	0 infections	**rate=0%**
Oct 2014- March 2015	0 infections	**rate=0%**	4 infections (Risk scores	208 ops **rate=1.9%**	1 infection (Risk scores	199 ops **rate=0.5%**
April-Sept 2015	2 infections (Risk scores 1,2)	193 ops **rate= 1%**	5 infections (Risk scores 1, 1,2,1 ,1)	153 ops **rate=3.3%**	0 infections	181 ops **rate=0%**
UK Mandatory Surveillance *(Risk score of 1)* *(Risk score of 2)*		(2011) *1.1%* *2.3%*		(2011) *0.8%* *1.3%*		n/a

Saving Lives Audits

The Saving Lives Observation Audits are done monthly, on every ward, by the IPCT the results are reviewed by the Assistant Directors of Nursing (ADNs) who present a quarterly action plan presented to the IP&C Committee. The Hand Hygiene Audits use the Modified Lewisham Audit Tool whereby an observation of hand hygiene (using the WHO 5 Moments). The Community hospital Staff, produce the hand hygiene audits and from March 2016 the Matrons will produce the peripheral canulae and urinary catheter audits.

A summary of the Saving Lives audits and subsequent actions are shown below:

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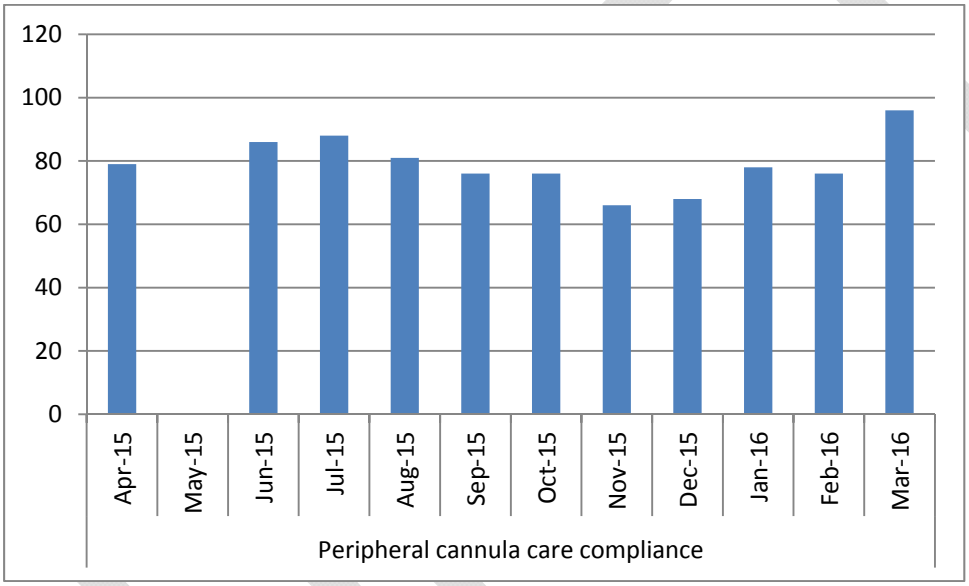
Community Hospital Hand Hygiene compliance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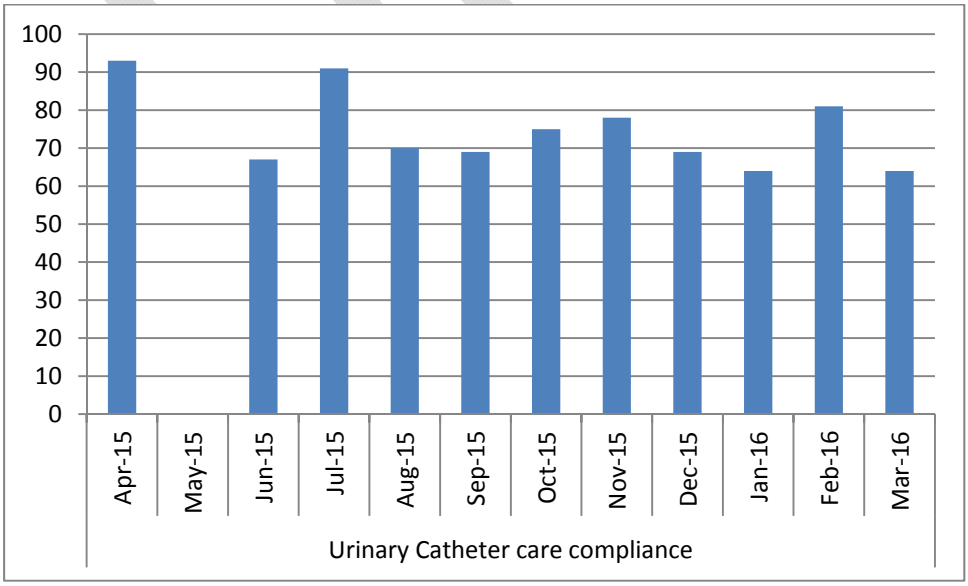
Peripheral cannula care compliance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Urinary Catheter care compliance

The actions to improve the Saving Lives Urinary Catheter compliance include teaching wards by the IPCT and the Urinary Catheter Working Group will be implementing the patient held document, 'Urinary Catheter Passport'. To facilitate this it will be a KPI for the Joint Infection Prevention and Control Committee.

Infection control liaison practitioner group - for the acute hospital was re-launched in October 2015. The meetings are bimonthly and consist of a half hour presentation and a half hour discussion regarding ward/unit issues. The next meeting in June will be attended by the chief Executive of the Trust and the Community liaison nurses have been invited. For the Community – the group meets 3 times a year; the membership consists of community hospital staff, district nursing staff, G.P. practice staff, podiatry staff and care home staff. The meetings are held at Newton Abbot Hospital where there is discussion of relevant topics, new or updated information and members also bring their queries/concerns about infection control to the meeting.

Personal Protective Equipment (PPE) Audit

In February 2016 a Torbay hospital audit of, 20 clinical areas', compliance with PPE and Isolation practices was made and feedback was given at the time of the audit. The Community hospitals will have the PPE audited in May 2016.
To improve the PPE Audit scores the Mandatory IP&C training for 2015/16 will be PPE and the Hiblio training videos can be seen in Appendix 3. The audit will be repeated next year.

PPE Audit Results (>95% is a pass)	No's Counted	Corre-ct PPE	Removed Correctly	Disposed properly	Hand Hygiene Preformed	Total
Allerton	3 (2 Dom & 1 HCA)	100%	66%	100%	100%	92%
Ainslie	3 (3 HCA)	66%	33%	100%	100%	75%
Cheetham Hill	4 (1 Physio, 1 SN & 2 HCA	50%	50%	50%	50%	50%
Cromie	3 (1 Dom, 1 SN & 1 HCA)	100%	100%	100%	100%	100%
Dunlop	4 (1 HCA, 1 Cons & 2 SN)	100%	100%	100%	100%	100%
EAU 3	3 (1 Dom & 2 HCA)	100%	100%	100%	100%	100%
EAU 4	4 (2 DR, 1 SN & 1 HCA)	100%	100%	100%	100%	100%
Ella Rowcroft	3 (3 HCA)	33%	100%	100%	100%	83%
Forrest	2 (1 Dom & 1 HCA)	100%	100%	100%	100%	100%
George Earle	4 (2 SN & 2 HCA)	75%	75%	75%	75%	75%
ITU	2 (2 SN)	100%	100%	100%	100%	100%
Louisa Cary	3 (1 DR, 1 HCA & 1 SN)	100%	100%	100%	100%	100%
Midgley	4 (2 HCA, 1 SN & 1 DR)	100%	50%	50%	50%	63%

Simpson	4 (3 HCA & 1 Physio)	25%	100%	100%	100%	81%
Turner	3 (1 Dom, 1 HCA & 1 SN)	100%	100%	100%	100%	100%

DR= doctor, SN= staff nurse, HCA= healthcare assistant

Public Health England (PHE) National Surgical Site Infection Surveillance reports Reports 2014/15

The National Surgical Site Infection Surveillance (SSIS) uses standard methodology and post-discharge surveillance to benchmark trusts on post-operative infection rates. Post-discharge surveillance for 3 months is used so results are available about 6 months later.

Site of surveillance	Duration of surveillance	TSDFT SSI Rate	National SSI Rate
Total knee replacement	Jan-March 2015	1.0%	0.5%
Total Hip Replacement	Oct-Dec 2015	results to follow	

Compliance with IP&C Mandatory Training

A summary of the TSDFT training figures in January 2016 is tabled below and the DIPC contacts the lead managers of areas with compliance <90% for IP&C, for their action plans, on a quarterly basis.

To facilitate training the IPCT have developed Hiblio training videos for PPE (Very high risk, infectious droplet and Standard) and hand hygiene so that the videos can be used as part of Mandatory Infection Control Training and improve compliance by having e-learning (see appendix 3).
The DIPC will meet with the Horizon Centre Lead for mandatory training in May 2016 to develop an action plan and in the meantime managers of poorly performing areas have been contacted by email.

TSDFT training figures January 2016	Area/ Service	% Compliance with IP&C Mandatory Training
Torbay Hospital	Corporate	83
	Estates	77
	Medicine	80
	Surgery	92
	WCD	90
	R&D	83
Community	Corporate	95
	Southern Devon	93
	Torbay	86
	Hospitals	86
	Professional practice	87
TSDFT Total		85

15. Outbreaks and Serious Incidents Requiring Investigation

There have been five SIRI (Serious Incident Requiring Investigation) reported on the STEIS (Strategic Executive Information System) database and one was an outbreak of *C difficile*, two patients with *C. difficile* in part 1 of the death certificate and three MRSA bacteraemias.

Organism, Ward(s) affected & Nos. affected	Date of samples	Date of RCAs	Outcome
C. difficile outbreak	9/3/16 & 26/3/16	23/3/16 & 14/4/16	Both patients admitted to A bay on Cheetham Hill ward in March16 and a delay in HPV treatment of the bay due to bed pressures in March16 from simultaneous seasonal influenza and Norovirus. **Action;** HPV requirement is now reviewed daily in Control Meeting.
C. difficile part 1 on death certificate, in one patient.	6/05/15	11/05/15	Very elderly, frail patient transferred from Brixham hospital to Torbay hospital for treatment of hospital acquired pneumonia and AKI. Patient had a GI bleed with malaena and too unwell for further investigation. The *C. difficile* was treated aggressively, including IVIG. Patient died. **Action;** None
C. difficile part 1 on death certificate, in one patient.	1/06/15	8/06/2015	Elderly patient treated correctly for pneumonia and the first loose stool was positive for *C. difficile*. The patient was treated but died. **Action;** None
MRSA bacteraemia	8/08/15	10/08/15	Admitted in June15, transferred from EAU4 to Turner ward. Pressure sores on admission, had peripherally inserted central venous catheter (PICC) inserted then had chemotherapy, became neutropenic and blood cultures from PICC & tip grew MRSA. All patient surface screens & ward screens were negative. **Action;** reviewed all staff who accessed the PICC before the bacteraemia. Bank & Agency staff no longer allowed to access PICCs on Turner or RGDC.
MRSA bacteraemia	7/02/16		Admitted A&E with severe disease and spent 16 hours in A&E. First 2 sets of blood cultures & ascitic tap all no growth but there was no admission MRSA screen. Patient febrile so rpt BCs on grew MRSA but no peripheral cannula infection. The source could be a possible enteropathy diagnosed on CT scan. **Action;** Patient Flow Board has approved IP&C procedures for patients staying in A&E overnight.

MRSA bacteraemia	10/02/16	no formal RCA as a blood culture collection contamin-ant	Young child admitted collapsed to gain venous access emergency scalp cut-down in Resus. Blood cultures taken from this site. MRSA status not known at this time so not treated). Surface swabs grew MRSA and child had cradle cap. **Action;** None

16. Infection Prevention and Control Annual Forward plan for 2016/17

TSDFT Annual Programme of Work2016/17:		Action / Leads & Responsible Work Stream if applicable	Completion date
i MRSA Control & MRSA /MSSA bacteraemia control	**KPI one– stay within Zero Tolerance for MRSA bacteraemia.**	**IP&CT -Quality Improvement Group**	**March 2017**
	KPI two- Reduce MSSA bacteraemias, acquired >48 hours after admission, by 5%	**IP&CT -Quality Improvement Group**	**March 2017**
	Hand Hygiene Compliance with IPC induction training delivered to all clinical staff >90%	DIPC & Horizon Centre– Workforce & Organisational Development Group	March 2017
	Continue performing Saving Lives Hand Hygiene audits - monthly if score <95% repeat weekly until =/>95%.	Hospital Care ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
	Perform Saving Lives Hand Hygiene audits within an annual rolling programme; Community nursing, Out-of-hours Service, Crisis Response, Learning Disability sites, Podiatry teams, Lower Limb Therapy Services, Castle Circus (Bowel & Bladder {Devon Staff}, Sexual Health, Orthotics/ Podiatry), Intermediate Care, Health Visitors, Specialist nurses, School nurses.	Community Care ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
	Continue to monitor bank workers, who have been with the trust >12 months, compliance with IPC mandatory training, by liaising with Recruitment / Temporary Staffing Manager.	DIPC – Workforce & Organisational Development Group	review May, July, Sept, Nov16 & Jan17

Educate patients and carers (by issuing PIL), with a new diagnosis of MRSA, about: the benefits of effective hand decontamination the correct techniques and timing of hand decontamination when it is appropriate to use liquid soap and water or handrub (audit to check that Community & Hospital patients have received PILs)	All ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
<u>Peripheral canulae & CVCs</u> Continue performing Saving Lives peripheral canulae-ongoing care audits - monthly if score <95% repeat weekly until =/>95%.	Hospital Care ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
Continue performing Saving Lives CVC-ongoing care audits (on Turner, RGDC & ICU) - monthly if score <95% repeat weekly until =/>95%.	Hospital Care ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
<u>PPE</u> Annual PPE audits of all hospital wards and a rolling programme for Community nursing, Out-of-hours Service, Crisis Response, Learning Disability sites, Podiatry teams, Lower Limb Therapy Services, Castle Circus (Bowel & Bladder{Devon Staff}, Sexual Health, Orthotics/ Podiatry), Intermediate Care, Health Visitors, Specialist nurses,	All ICNs - Quality Improvement Group	March 2017
Compliance with IPC mandatory PPE training delivered to all clinical staff >95%.	DIPC & Horizon Centre– Workforce & Organisational Development Group	March 2017
<u>RCA</u> Perform RCAs on all patients with a *Staph aureus* bacteraemia, >48 hrs after admission to hospital, and report action plans to the IP&C Committee.	IP&CT- Quality Improvement Group	review May, July, Sept, Nov16 & Jan17

	<u>SUI</u> Report all MRSA bacteraemia related deaths, where the MRSA bacteraemia was isolated >48 hrs after admission to hospital, and Part 1 death certificate *C. difficile* deaths, where *C. difficile* was diagnosed >72 hrs after admission to hospital.	IP&CT- Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
	<u>Surveillance</u> PHE National Surgical Site Infection Surveillance (SSIS) of; Trauma and Orthopaedic THR & TKR, Vascular, Large bowel & Hysterectomy. Demonstrate year on year reductions in SSI rates.	Hospital Care ICNs & T&O Directorate -Quality Improvement Group	March 2017
	Ongoing, lab-based, ward, T&O prosthetic joint, deep Surgical Site Surveillance (SSI) reported to Surgeons at Governance meetings bi-annually.	DIPC-Quality Improvement Group	March 2017
	Central line associated blood stream infection (CLABSI) and central catheter related blood steam infection (CRBSI) surveillance for PICC and Midlines.	DIPC-Quality Improvement Group	March 2017
	Request SDTCCG engage with procurement GP Practices in flagging MRSA positive patients on their computer patient records or any other system that alerts GPs when prescribing. *(Also CDT+, CDTPCR+, ESBL)*	SDTCCG & TSDFT DIPC- *Clostridium difficile* Working Group.	September 2016
ii C.difficile control & Norovirus outbreaks	**KPI three – stay within CCG / Monitor Ambitions for CDT+**	**IPCT -Quality Improvement Group**	**March 2017**
	KPI four – No ward closures due to Norovirus for > 12 days.	**IPCT-Quality Improvement Group**	**March 2017**
	<u>Hand Hygiene</u> As for KPI 1 & 2.		
	<u>Operational</u> Isolate patients with infectious or potentially infectious diarrhoea within 2 hours.	Operations & Hospital Care ICNs - Quality Improvement Group	September 2016

	Siderooms or bays occupied by patients with symptomatic C difficile infection must have an HPV Deep clean asap and if not completed by 5d an incident form completed.	Operations & Hospital Care ICNs - Quality Improvement Group	September 2016
	Annual Deep Clean of all clinical areas & pro-actively use HPV from May 2016 to avoid increased incidence of *C. difficile* (except for paediatric & obstetric wards & ICU).	Operations, Hospital Care ICNs & Hotel Services - Capital Infrastructure & Environment Group	March 2017
	RAG rating of siderooms. Working to have updated twice a day but ward clerks and ward staff will have to have training to achieve this.	Ward Managers - Workforce & Organisational Development Group	September 2016
	Community Intermediate Care (both block contracts & contracted places) within Care homes will receive telephone support when a patient, with a recent h/o symptomatic *C. difficile*, is discharged.	Community ICNs - Quality Improvement Group	September 2016
	<u>Audit</u> IP&C will collate monthly Matron's audits on ward Cleanliness & Decontamination and feedback to ADNs, when not performed for 2 consecutive months.	Lead Hospital ICN & DIPC- Quality Improvement Group	September 2016
	IPS audits of all clinical areas every 2 years. Obtain 3 monthly updates against action plans from Patient Environment Group and Joint Estates , Hotel Services & IP&C Group.	All ICNs, Matrons, Estates, - Quality Improvement Group & Capital Infrastructure & Environment Group	March 2018
	<u>RCA</u> Perform RCAs on all patients diagnosed with *C difficile*, >72 hours after admission to hospital, and report action plans to this Committee.	IP&CT- Quality Improvement Group	September 2016

	<u>Antimicrobial Review</u> Continue monthly reporting of Saving Lives antimicrobial audits. And ensure action plans in place.	Antimicrobial Pharmacist- Quality Improvement Group	September 2016
	IP&CN C diff ward rounds & twice weekly IP&C WCC check of all *C. difficile* alert patients.	Hospital Care ICNs - Quality Improvement Group	September 2016
	Antimicrobial ward rounds and assurance that the Antimicrobial audit loop has been closed	Antimicrobial Lead- Quality Improvement Group	September 2016
	<u>Estates</u> A&E: Fit a new sink & IPS panel in restraint room, cubicle 8 &11. Refurbish sinks, taps & IPS panels in adult cubicles 1-7, 10, DOA room, three in Resus & sluice, paediatric cubicles 1,2 & examination area 2 and refurbish male staff toilet. And other Estates work as per IPS audit. Warrington Ward: renew sinks/ IPS panels. And other Estates work as per IPS audit.	Estates- Capital Infrastructure & Environment Group	March 2017
	Support Estates with a Capital bid for a centralised, trustwide renewal of macerators & dishwashers.	DIPC & Estates- Capital Infrastructure & Environment Group	September 2016
	Increased numbers of Ainslie ward siderooms – currently with Capital Projects Phase I & II. Hetherington block consultant and secretary offices share kitchens and toilet facilities with wards – currently with Capital Projects Phase I & II. Remove patient toilets outside of kitchens on wards in Hetherington block.	Estates- Capital Infrastructure & Environment Group	March 2017
	KPI five – Oversee the implementation programme of the Urinary Catheter Patient Passport scheme.	**IPCT -Quality Improvement Group**	**March 2017**

iii Urinary catheter care/ESBLs /E. coli bacteraemias			
	Torbay Hospital and Community Hospital and GP PNs use the Urinary Catheter Care Passport	Deputy DN Trustwide Business Units	September 2016
	KPI six – Reduce E.coli bacteraemias, acquired >48 hours after admission, by 5%	**IPCT -Quality Improvement Group**	**March 2017**
	Report Saving Lives ongoing urinary catheter care - monthly if score <95% repeat weekly until =/>95%.	Hospital Care ICNs - Quality Improvement Group	review May, July, Sept, Nov16 & Jan17
	Study of 50 patients with E. coli bacteraemia, acquired in Primary Care, to establish times of admission to hospital and whether seen by GP or other Healthcare Services beforehand.	DIPC- Quality Improvement Group	September 2016
	Work with Sepsis Team to assist in implementation & monitoring of Sepsis CQUIN	Hospital Care ICNs - Quality Improvement Group	September 2016
Miscellaneous	Receive Water Safety Reports Bimonthly for assurance	Water Safety Group- Capital Infrastructure & Environment Group	September 2016
	Review Critical ventilation annual validation for assurance	DIPC- Capital Infrastructure & Environment Group	September 2016
	Oversee FFP3 mask fit testing compliance for assurance. Assist Horizon Centre with training protocols.	DIPC & Horizon Centre– Workforce & Organisational Development Group	September 2016
	Work with OCH to improve uptake of staff Influenza vaccination.	OCH & IP&CT - Workforce & Organisational	March 2017

17. Torbay and South Devon Foundation Trust Infection Prevention and Control Strategy – May 2016 – March 2018

Background

The Health and Social Care Act 2008 *Code of Practice on the Prevention and Control of Infections and Related Guidance.* 2010, *Healthcare-associated infections* qs113 February 2016, *Prevention and control of healthcare-associated infections* qs61. April 2014 and *Healthcare-associated infections: prevention and control in primary and Community Care* cg139. March 2012 – all form the basis of the Torbay and South Devon Foundation Trust (TSDFT) Infection Prevention & Control (IP&C) Strategy. This Strategy will be implemented within the IP&C Annual Forward Plans and monitored by the Quality Improvement Group.

1. Strategic Objectives

Engage all staff from Board to Ward in pro-actively preventing healthcare acquired infections.

Manage effectively and efficiently patients with healthcare acquired infections, colonised or infected with alert organisms and conditions.

Achieve the DoH targets for *Clostridium difficile* infections and MRSA bacteraemias.

At all times have in place a fully functioning Infection Prevention and Control Team.

Ensure care workers are protected from infection.

At all times aim to reduce the incidence of avoidable harm.

2. Strategic Goals

Provide evidence based policies on Infection Prevention and Control to staff and volunteers as appropriate.

Reduce non-compliance in Saving Lives Hand Hygiene to a minimum of 5%.

Ensure MRSA Screening compliance reaches >90% and ensure the MRSA and MSSA screening protocols are in place.

Ensure appropriate placement of patients with healthcare acquired infections, colonised or infected with alert organisms and conditions. Ensure appropriate Personal Protective Equipment (PPE) is in place and appropriate training on correct use is delivered.

Matrons' Environmental Audits of Standards of Cleaning, Decontamination and Fabric of Environment all have Action Plans in place & where appropriate placed on the Risk Register.

Ensure >95% of staff (including Agency & Bank staff) receive Infection Control Induction / Mandatory Training.

Compliance with Antimicrobial Prescribing Policies of >95%.

Legionella /Pseudomonas Control, in Water Systems, are in place with an up-to-date Trust policy which is audited as required by L8 Approved Code of Practice & HTM01-04.

Participate in PHE's Mandatory Healthcare associated Infection Surveillance and any other surveillance to reduce the incidence of avoidable harm.

Participate in Trust's Capital Planning by Infection Control being invited to all the meetings in the first instance. Ensure this is in Estates Project Planning Policy.

3. How these Strategic Objectives will be achieved

Both Hospital and Community

Ensure expertise and training for all IP&C staff in post.

Undertake to deliver a safe, clean environment for patients by maintaining adequate resources – Trained Nursing staff and Hotel Services staff and Equipment to conform to National Standards.

All staff will receive Pre-employment screening, vaccinations and advice on how to protect themselves and their patients from Healthcare Associated Infections.

IP&C Committee will obtain assurance on Mandatory / Induction IP&C training of all staff including Bank & Agency from the Horizon Centre.

IP&C to work closely with the Decontamination Group.

Community

Develop an organisational structure for IP&C in the Community by engaging IP&C Leads in the Five Localities.

Develop a system to obtain baseline Hand hygiene audits, reporting & re-audits and where applicable PPE audits, within the Community Services and from this data develop further training if required.

Develop a system to obtain baseline Saving Lives; peripheral cannulae ongoing care, CVC ongoing care & urinary catheter ongoing care in; Community nursing, Out-of-hours Service, Crisis Response, Specialist nurses and others as appropriate.

Set-up baseline IPS audits & reporting, re-audit systems in in-patient care areas such as

Set-up baseline IPS audits & reporting, re-audit systems in higher risk areas such as lower limb clinics, podiatry, bowel and bladder clinics.

Hospitals

Matrons' Audits to be reported to IP&CT and action plans discussed with ADNs. Non-compliance will be monitored by the IP&C Committee via the ADNs' Quarterly HCAI Reports.

The IP&CT's IPS Audits' Action Plans to be monitored every 3 months by the Environment Group and if required escalated to the IP&C Committee.

Owing to the lack of sideroom facilities the Infection Control Team will Risk Assess patients requiring isolation and place highest risks in siderooms. Inappropriate placement of incorrectly placed patients will instigate an Incident form and will be monitored by the IP&C Committee.

IP&CT will assist with planning and implementation of the Trust's Annual Deep Cleaning Programme working with the Directors of Operations and Nursing to achieve the maximum use of decanting facilities available to achieve the programme.

Infection Control will guide Capital Planning in the direction of increasing siderooms, increasing distance between beds and increasing en-suite facilities, on Medical wards and the EAUs.

Ensure all Contractors receive appropriate Infection Prevention and Control advice and training whilst working on site.

4. External Reporting

Progress on the implementation of this Strategy will be reported to:
Clinical Commissioning Group
Monitor
Care Quality Commissions Regulators

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***C. difficile* references**

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Appendix 1.

Torbay and South Devon NHS Foundation Trust Infection Prevention and Control Committee *Revised February 2016*

Constitution and Terms of Reference

1. Title

The Committee shall be known as the Infection Prevention and Control Committee (IPCC).

2. Strategy

To drive delivery of a Torbay and South Devon Infection Prevention and Control programme which follows the whole patient journey through the local health system.

Obtain Assurances from the TSDFT Directorates that this is performed and report the findings and exceptions to the Quality Improvement Group and via this Group to the Trust Board.

3. Function

a. Send an Annual Infection Prevention & Control Report to the Board and set Annual Infection Prevention and Control Forward Plan.
b. Monitor progress against Annual Plan and escalate significant risks to the Trust Board.
c. Review national guidance and statutory changes, and take appropriate actions.
d. To receive infection prevention and control reports (eg. from ADNs) and take / recommend appropriate actions. This includes;

i. Audit and Surveillance
ii. Incident reports
iii. Root cause analyses
iv. Training
v. Estates issues

e. To receive assurances on Water Safety and Critical Ventilation from Estates.
f. To receive assurances from the Decontamination and Patient Environment Groups.
g. Monitoring the infection prevention and control Risk Register and escalating any unmanaged or exceptional risks to the Quality improvement Group or Quality Assurance Committee.
h. Ensure there is a current Major Outbreak Plan as part of the health community contingency planning

4. Membership

The membership of the Infection Prevention and Control should include:-

a) Director of Infection Control and Prevention / Executive Lead
b) Lead Infection Control Nurses and or deputies
c) Non-Executive Director
d) Assistant Directors of Nursing
e) Operations Manager
f) CCDC Public Health England or representative
g) Local Authority representative
h) Occupational Health Physician or Nurse
i) Representative of Medical Staff Committee
j) Patient Safety Lead or representative
k) Representative Governor (service user)
l) Antimicrobial Lead Pharmacist
m) Director of Estates and Facilities or representative(s);
n) Care Home representative

When required the following people will be invited

a) Decontamination Lead
b) Clinical Specialties
c) Information / Performance analyst
d) Care Quality Commission Lead
e) AHP Representative
f) Quality and Safety representative for the CCG
g) Others as appropriate

5. Frequency of Meeting

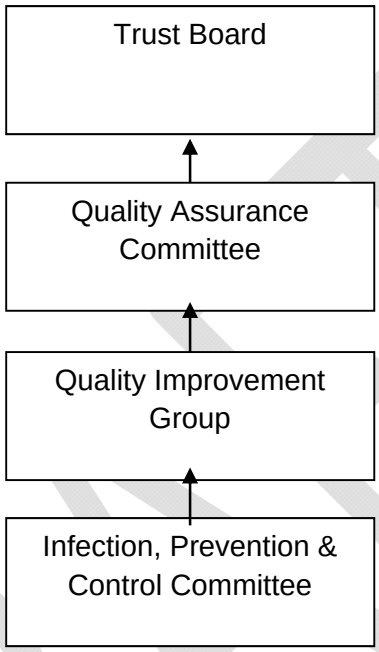
The meeting is bi-monthly.

For the committee to be quorate 60%, must be present and include either a Director of Infection Prevention and Control / Executive Lead.

6. Distribution of minutes

Minutes will be distributed to members, Chair of Quality Improvement Group and Chair of Quality Assurance Group and invitees as appropriate.

7. Accountability Arrangements



Appendix 2. External Peer Review Action Plan

Recommendation	Action	Person Responsible and Date	Progress Review	Completed
1. Review the role of the Director of Infection Prevention and Control (DIPC) and the need for a permanent position.	Discuss with all consultant microbiologists	Medical director/CN	April 2017	Agreed that review the situation in 2-3 years when Pathology CD tenure is completed.
2. Ensure regular communication forum with DIPC and chief executive(CEO)	CEO and Chief Nurse (CN) and DIPC to set up formal quarterly meeting	CEO and DIPC	April 2016	Agreed and booked meetings between CEO and DIPC.
3. Define role of Deputy Director of Nursing.(DDN)	CEO, CN & DIPC to agree	CEO, CN & DIPC	April 2016	Agreed by CEO and CN on 17/03/16 that the IP&C team have no managerial accountability to DDN but deputising for CN in professional practice such as non compliance with Infection Control procedures .
4. Clearly define a standard for reports/action plans to the Trust chief executive Senior Management Team and Trust Board to ensure appropriate assurances at each level of the organisation.	Agree essential reports and set up a template for reporting to the Quality Improvement Group QIG, Quality Approval Committee QAC.	DIPC & CN	April 2016	Agreed a template to be submitted to QIG.
5. Ensure processes are in place to ensure that timely IPC audit information and HCAI rates are easily accessible by ward staff and public areas.	IT to ensure there is a system for updating ward electronic dashboards Ensure ward information boards are up to date with saving lives and hand hygiene information	Gary Hotine DDN(Jacquie Phare)	 April 2016	 Completed – ward corridor dashboards in place.
6. Form a clinically focussed subcommittee focusing on shared learning, clinical challenges and escalating issues to the Infection Prevention and Control Committee.	Devolve responsibility changes to service delivery units so as Trust can use existing governance bodies so as becomes" business as usual" e.g. twice yearly feedback of RCA outcomes.	CN	April 2017	

Recommendation	Action	Person Responsible and Date	Progress Review	Completed
7. Review Isolation Policy to ensure that siderooms are prioritised for patients with transmissible diseases and multi resistant microorganisms.	Make training for On-call Managers mandatory regarding safe patient placement. Ensure staff are updating and using alerts on swift plus board.	On-call Manager Lead Liz Davenport Director of Operations	September 2016	
8. a) Ensure IPC risk assessment on symphony cannot be bypassed. b) Request that SwiftPlus has retrospective patient traceability thru hospital.	Ensure symphony cannot be printed off until infection control risk assessment completed by completing in triage which should be achieved within 15 minutes of arrival. Email Peer Reviewer that IHCS captures information	Michelle bell Associate director of Nursing medicine. DIPC and Lead nurse Infection Prevention and Control (IP&CLN)	April 2016 March 2016	Repeat audits have shown that Symphony is printed off after completion of the IP&C Risk Assessment. Completed
9. Consider inviting consultant microbiologist and microbiology biomedical scientist to the daily catch up meeting.	DIPC to email Dr Nadami regarding winpath and swiftplus system that allows time alerts to IP&CT Meet with head biomedical scientist to establish attendance and frequency especially during outbreaks	DIPC DIPC/ IP&CLN	May 2016	completed To meet in May16
10. Consider putting in place out of hours IPC nursing cover.	CN and IP&CLN to establish requirements such as an on call telephone system . Submit business case to the board.	CN and IP&CLN	September 2016	
11. Establish mechanisms for distributing learning and sharing good practice from HCAI RCAs in a timely fashion.	Establish appropriate meetings to feedback learning. Ensure immediate verbal feedback to appropriate area. Explore other pathways to feedback. (Refer to point 9 above)	Clinical Governance Leads.	September 2016	
12. Ensure CDT testing follows DOH guidance and ensure consistency as per peer peninsula Trusts	Look at DOH guidance and review SW peninsula testing.	DIPC	April 2016	Completed and compliant with DOH guidance. changing to GDH EIA screening from October 2016 in line with SW

				Peninsula
Recommendation	**Action**	**Person Responsible and Date**	**Progress Review**	**Completed**
13. Review Trust C difficile testing and sampling guidance to ensure that specimens are tested as per DOH guidance.	Resend SIGHT poster for display in sluices	IP&C team	April 2016	Completed
14. Develop formal escalation process for providing challenging among staff where IPC practice is not observed.	Develop a formal process for escalation of non compliance. To develop a nursing/professional Practice escalation policy Escalation for non compliance of all areas within the Trust i.e verbal abuse, uniform and hand hygiene	HR	April 2017	
15. Support and enhance the link nursing programme ensuring protected time for participation in the programme.	Explore developing a role for clinical risk champions that will incorporate infection control along with other risks Insert link nurse role in their job descriptions. Chief nurse to formalise time to be allocated.	CN	August 2016	
16. Expand Antimicrobial programme to audit compliance with guidelines and appropriateness. A rolling programme focusing on wards where C diff/or inappropriate prescribing is an issue	Commence Antimicrobial ward rounds Develop an Annual Forward Programme for Antimicrobial Prescribing which feeds into the IP&C Committee	Anti microbial Team/AT (Dr Tony Maggs & Becca Bowden)	September 2017	Under review by AT, in meantime increased 5 patients to be audited per month on all wards and EPP will link into Bugbuster3000 which allow remote auditing.
17. A formal escalation process for non compliance with trust antibiotic prescribing should be developed and implemented.	Include Antimicrobials prescribing compliance within template for QIG, QAC & board.	AT & DIPC	April 2016	
18. Revise the Trust hand hygiene incorporating the WHO hand hygiene audit tool.	Develop and submit a business case for employing band 2 to undertake hand hygiene audit. Explore existing budget monies.	DIPC & IP&CLN	April 2017	Reviewing IP&CT structure to obtain a B2 to audit.
19. The IPCT should consider creating the role of an independent auditor to carry out IPC audits which would release specialist nursing time.	Develop and submit a business case for employing band 2 to undertake hand hygiene audit. Explore existing budget monies	DIPC & I P&CLN	April 2017	As above
20. Details of insertion of invasive devices should be documented and audited for compliance on a recurrent basis.	Link Nurses or dedicated audit person to be established to do this Educate high risk areas	CN	August 2016	

Appendix 3 - Mandatory Infection Control, Personal Protective Equipment (PPE) & Ebola Training- development of Hiblio videos

Hiblio video on How to Wash your Hands
http://vimeo.com/hiblio/review/112791422/f7a0581a1a

Donning PPE for Standard Isolation Control
<iframe src="//player.vimeo.com/video/117927154?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Doffing PPE for Standard Isolation Control
<iframe src="//player.vimeo.com/video/117927155?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Donning PPE for Airborne or Risk of Splashing Infections
<iframe src="//player.vimeo.com/video/117926273?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Doffing PPE for Airborne or Risk of Splashing Infections
<iframe src="//player.vimeo.com/video/117927153?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe

Donning high risk waterproof suit PPE
http://vimeo.com/hiblio/review/112790699/375405c43c
<iframe src="//player.vimeo.com/video/112789754" width="500" height="281" frameborder="0" webkitallowfullscreen

Doffing high risk waterproof suit PPE
http://vimeo.com/hiblio/review/112789754/992f9fd4f5
<iframe src="//player.vimeo.com/video/112789754" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></ifr

Appendix 4 - IPS Audit 2015 – 2016 Programme

Order of Priority

Hetherington, Tower Block, EAU3/4, Orthopaedics, Maternity, Outpatients

Ward Name	Date Of Last Audit	Compliance	Date of Audit	Compliance	Date Audit Sent	Reminder Sent	Update Required
A&E	11/10/12	63%	05/10/15	78%	22/10/15	21/01/16	
Ainslie	08/10/12	83%	15/11/15	88.75%	23/12/15	01/04/16	
Allerton	01/05/13	88%	13/11/15	92%	26/11/15	10/03/16	
Ante Natal	15/05/14	77%	10/02/16	84.16%	17/02/16		
CCU	31/07/12	77%	27/11/15	86%	14/12/15	1/04/2016	
Cheetham Hill	17/08/12	73%	09/07/15	88%			? send out due to date as was going to be refitted
Cromie	07/05/12	73%	18/11/15	91%	26/11/15	10/03/16	
Dunlop	24/07/12	81%	11/11/15	82%	14/12/15	01/04/16	
EAU3	07/02/13	87%	06/10/15	87%	06/11/15	11/02/16	
EAU4	27/02/12	75%	08/10/15	83%	22/10/15	27/01/16	
Elizabeth	-						
Ella Rowcroft	10/09/12	87%	24/11/15	85%	14/12/15		
Forrest	15/01/13	92%	15/10/15	76%	02/11/15	03/02/16	
Fracture Clinic			08/12/15	67%	18/12/15	01/04/16	
George Earle	19/07/12	72%	19/10/15	55%	22/10/15	21/01/16	
ITU	28/06/12	70%	25/02/16				
John Macpherson	22/01/13	92%	01/02/16	76.15%	18/02/16		
Labour	21/06/12	71%	1/6/02/16	80.08%	10/03/16		
Louisa Cary	04/12/12	86%	15/12/15	80.79%	23/12/15	01/04/16	
McCallum	10/11/10	95%	20/10/15	89%	22/10/15	21/01/16	
Midgley	11/07/12	78%	16/04/15	88%	18/05/15	22/10/15	
Outpatients			11/03/16	80.83%	14/03/16		
RGDU	10/12/12	72%	22/12/15	90%	28/01/16		
SAVW	09/05/14	79%	23/02/16		10/03/16		
Simpson	02/07/12	72%	09/10/15	84%	06/11/15	11/02/16	
TAIRU			02/02/16	81.2%	18/02/16		
Turner	04/12/13	87%	09/12/15	86%	28/01/16		
Warrington	02/05/12	68%	04/11/15	75.32%	03/12/15		

Ward	Identified Method of Achieving Deep Clean	Planned Month to Time	Currently Outstanding	Next Outstanding Date	Next Outstanding Area
A & E	In-Situ - Cubicle by Cubicle, Overnight.	October	All		
Ainslie	Decant to Warrington	May		21.05.16	Majority of Ward
Allerton	Decant to Cromie (Cromie on Warrington)	August		01.08.16	Majority of Ward
Cheetham Hill	Decant to Warrington	December		22.09.16 23.09.16	Side Room 26 Side Room 28
Cromie	Decant to Warrington	July	General Areas, SR1, SR2, SR3, Bay 5-8, Bay 11-14, Bay 23-26		
Delivery Suite	In-Situ - Room by Room	February	Whole Ward	22.01.16	changing room
Dunlop	Decant to Warrington	January		02.06.16	Bay 3, General Areas
EAU3	In Situ - Bay by Bay, Room by Room	October	Majority of Bays	16.04.17	Office
EAU4	In Situ - Bay by Bay, Room by Room	September	Bay 6, Bay 8, general areas		
Ella Rowcroft	Decant to Warrington	April	Whole Ward		
Forrest	Decant to Cromie (Cromie on Warrington)	August			
George Earle	Decant to Cheetham Hill (Cheetham on Warrington)	December		16.05.16	Majority of Ward
ICU	In Situ - Bay by Bay, Room by Room	May	General Areas	Mar/Apr	Majority of Ward
John McPherson	In Situ - Bay by Bay, Room by Room	February	SR1, SR2, SR4, SR5, SR7, General Areas		
Louisa Cary	In Situ - Bay by Bay, Room by Room	June	Whole Ward		
YPU	In Situ - Bay by Bay, Room by Room	June	Whole Ward		
McCallum	In Situ - Weekends	March	Whole Ward		
Midgley	Decant to Warrington	November		16.10.16	Bay 4, Bay 3
SCBU	In Situ - Bay by Bay, Room by Room	February	Whole Ward		
Simpson	Decant to Warrington	November		03.05.16	General Areas
TCCU	In Situ - Bay by Bay, Room by Room	January	Whole Ward		
Turner	In Situ - Bay by Bay, Room by Room	May	Bay 7&8, Store Treatment Roo		
Warrington	Clean following occupation of another ward.	May		Jan-17	Whole Ward

Appendix 5 – Annual Deep Clean of Wards at Torbay hospital

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	25 May 2016
Title:	Chief Operating Officers Report
Lead Director:	Liz Davenport
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

To report sets out progress against key delivery objectives of the Trust including implementation of the planned care model changes.

Key Issues/Risks

The risk outlined in relate to compliance with key performance targets:

- Workforce gaps in clinical specialities including radiology and neurology
- Bed pressures that impact on inpatient surgery cancellations
- Ability to secure outsourcing capacity in some specialities including Upper GI

The care model implementation risks relate to progress with the consultation and the potential implications for delay in delivery of community services.

Recommendations:

To **consider the progress and assurances within this** report

Summary of ED Challenge/Discussion:

The Executive Team has reviewed the performance trajectories and tested the potential risks to delivery including impact on financial plans. The discussions informed the proposed change in the 4 hour performance trajectory presented to the systems resilience group.

The care model implementation plans have been reviewed with a particular focus on ensuring timely delivery of the Coastal changes now money has been released.

Internal/External Engagement including Public, Patient and Governor Involvement:

The Care model changes will be subject to public consultation

Equality and Diversity Implications:

An Equality Impact assessment has been completed on the care model changes.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	25 May 2015
Report From:	Chief Operating Officer
Report Title:	Report of Chief Operating Officer

1 Purpose

To provide the Board of Directors with an update against key operational issues

2 Provenance

The report is informed by the following:

- Minutes and action log from the Care Model Operational Group
- Minutes and action log from Senior Business Management Team
- Presentation to Systems resilience Group on 4 hour wait trajectory
- Minutes of the Executive Team

3 Care Model Delivery

The decision of the Board of Directors to support investment in the care model has been communicated to the project leads for care model delivery. The group agreed a methodology to monitor overall delivery against plans through the programme office as well as key requirements of each of the project leads to develop their detailed plans and benefits realisation profile progress each of the approved schemes. All schemes that were not approved at this stage have been asked to review the costs of the planned schemes, which will then be reviewed, and subject to discussion and approval through the care model operational group and Care Model Executive.

The programme of implementation of the agreed changes is being progressed this includes:

Frailty

The team is located in Acute Medical Unit enabling MDT assessments to be completed on patients who meet the identified criteria for the service. The Team is routinely collecting data on the effectiveness of the services which has demonstrated that of the first 76 patients seen by the team 87% were able to return home the same day with the support of the discharge to assess team. This data is matched with high service user satisfaction ratings for the service.

Wellbeing coordination

The approval of funding to support delivery of the wellbeing agenda has allowed recruitment to the posts to commence in partnership with the voluntary sector. The posts have been advertised and it is expected that staff will be in post in the next 8 weeks.

The Prevention strategy that informs the work plan has been finalised and a work plan developed. This will be taken forward with the wellbeing teams at an event planned for 30 June 2016.

Multi- Long Term Conditions

Recruitment of patients is underway through GPs and specialist services. A number of GPs across localities have expressed interest in being involved in the clinics. A test of change has been planned for the 2nd June which will inform patient flows and aid the finalisation of the implementation plans and consistent set up of the service across localities.

Seeking advice from the ICO (SAICO)

The service is now being utilised across a broader number of specialities with orthopaedics joining at the beginning of May. A significant number of inquiries are being received through the process with an evaluation of impact due to be completed in 3 months.

Community service changes

Each of the localities are developing their implementation plan in line with the service specification for community hubs and health and wellbeing teams and resources allocated. This includes establishing partnership working arrangements with Devon Partnership Trust, provider of mental health and learning disability services and other key community stakeholders.

The developments in intermediate care are being progressed by the CCG who are inviting expressions of interest from providers.

Coastal implementation is being taken with intention to increase staffing levels at Dawlish Hospital to agreed staffing levels which will allow for the community beds to be consolidated at Dawlish Hospital and work to commence on the implementation of the Rehabilitation service at Teignmouth. It will also allow appointment to roles within the Health and Wellbeing Teams. These changes are consistent with plan agreed following consultation on the Coastal locality last year.

New ways of working is key to delivery of the new care model and to support this work is underway on implementation of a strengths based approach to service delivery. Arrangements have also been put in place to commence the implementation of a model of personalised care planning which will be delivered in partnership with My Support Broker and the Community Development Trust.

The final draft of the Community Services Consultation document was completed on 13 May 2016 in readiness for presentation to Health Overview and Scrutiny Committees. The document is attached for information. The Trust has requested legal advice on the potential implications of progressing some of the care model changes ahead of the proposed consultation model and expects to receive this information shortly.

The University Team leading the evaluation project will be spending time with each of the project leads to get greater understanding of the care model changes. This will

inform a set of proposals on the KPIs to be used to assess impact of the care model changes.

4. Performance trajectories

The Trust has submitted trajectories to NHE and NHS Improvement setting out planned timescales for delivery against constitutional targets. There is an opportunity to refresh these and submit on 23 May 2016. The submitted trajectories needed to be agreed with the CCG. Compliance with these standards will be key to secure the sustainability and transformation fund (STF). Details of the agreed change to Trajectory for 4 hour wait are included in the Urgent Care Improvement Plan update.

The trajectories that have been submitted based on a detailed analysis of capacity and demand forecasts and an assessment of the risks to delivery. This is reviewed formally at the RTT and Diagnostics Assurance Group. The ongoing risks to compliance include:

- Workforce gaps in clinical specialities including radiology and neurology
- Bed pressures that impact on inpatient surgery cancellations
- Ability to secure outsourcing capacity in some specialities including Upper GI

5 Cost Improvement Plans

The Finance Committee and the Senior Business Management Group have approved proposals to set up a Financial and CIP Oversight Group. This group will review all plans include an assessment of the quality and safety impact of all plans. The group will also monitor compliance with plans and support named leads in addressing in any barriers to delivery.

Recommendation

To **note** the contents of the report

Liz Davenport

Chief Operating Officer

25 May 2016

REPORT SUMMARY SHEET

Meeting Date:	25 May 2016
Title:	Workforce and OD Board Report
Lead Director:	Martin Ringrose, Interim Director of Human Resources
Corporate Objectives:	• Safe, Quality Care and Best Experience • Improved wellbeing through partnership • Valuing our workforce • Well led
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group/Workstream 4.
- To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks:

- The Directorates objectives for 2016/2017 are included in section 2
- The revised key metrics performance targets for 2016/2017 are included in section 3.2
- The staff appraisal rate for the Trust is 82% which benchmarks favourably with other local trusts (see section 3.3). The target staff appraisal remains at 90%.
- The sickness absence rate was 4.10% in March 2016 which is above the target rate of 4.00% set for that month (see section 3.5).
- The vacancy factor for the Trust at the end of March 2016 was 7.92% and for qualified nursing 6.69%. However in key patient areas the rate for qualified nurses was 9.09% (see 3.6 and 3.7 below). This report includes details of short term and longer term strategies to reduce the vacancy gap and manage demand and supply.
- The Trust has negotiated an arrangement to provide the payroll service to Yeovil District Hospital NHS Foundation Trust. Details are included in section 5.4.
- Recommendations of the Speak Up Review continue to be embedded and the development of a culture whereby staff are encouraged to raise concerns, confident in the knowledge that they will be listened to, that action will be taken and that they will be thanked and acknowledged for living the values of the NHS. See sections 6.4 - 6.6
- Work continues to secure the occupation health service from our preferred supplier Optima Health. It is anticipated that contractual arrangement s will be agreed later this month with service provision commencing in August 2016.

Risks

- A range of initiatives are being actioned and/or considered in support of trust wide recruitment issues, Section 6.7 refers.
- Recruitment to Band 5 nursing posts remains an issue which is consistent with other Trusts. A range of measures to mitigate the issue are contained within this report.
- Medical recruitment remains a challenge in key areas as reported in Section 6.9.2.
- Agency capped rates reduced further from 1st April 2016. The Trust continues to report weekly to monitor on all agency usage that is above the capped rate or through a non-framework provider. Early dialogue with the NHS Improvement Agency is taking place in an endeavour to address this issue (see section 6.8 which includes measures to reduce agency usage).
- Implementation of the junior doctor contract by 3rd August 2016 is an anticipated challenge which is consistent with the national picture (see section 6.9.1).

Recommendations:

The Board is asked consider and discuss the assurance provided by the contents of this report.

Summary of ED Challenge/Discussion

The level of OD support available to the restructuring process within the operational divisions.

An assessment of the impact of Apprentices on reducing HCA flexible spend.

Internal/External Engagement including Public, Patient and Governor Involvement:

Governor Observer on Workforce and Organisational Development Group (Workstream 4)

Equality and Diversity Implications:

None.

PUBLIC

Board of Directors
Workforce and Organisational Development Directorate
25th May 2016

1.0 Purpose and Content of the Report

1.1 Report Purpose

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group (Workstream 4).
- To provide the Board with assurance on workforce and organisational development issues.

1.2 Report Content

- A summary of the workforce and OD corporate objectives for 2016/2017.
- A summary of progress on key performance indicators. These performance indicators are included in the Trusts monthly workforce and OD scorecards in the appendices and include key targets and monthly trends.
- Detail on actions and initiatives linked to the objectives and key performance indicators.

2.0 Workforce and OD Objectives

2.1 Objectives 2015/2016

The following Workforce and Organisational Development objectives were agreed by the Workforce and OD Group for the 2016/2017 financial year. The objectives are designed to support the Trusts overarching corporate objectives. This report to the Board includes progress towards achievement of each of them.

2.1.1 Supporting large scale and rapid structural change

To support the major structural change needed to allow the ICO to effectively implement the new model of care.

2.1.2 Implementation of medical workforce changes

To support the implementation of wide scale medical workforce changes.

2.1.3 Changing Trust culture to reflect a community based approach to care

Develop leadership and culture throughout the organisation to ensure the values and beliefs of the organisation and support the implementation of the new model of care.

2.1.4 Making the Trust a more attractive and competitive employer

Developing recruitment and retention strategies that make the Trust an attractive organisation to attract and retain staff.

2.1.5 Developing and implementing new ways of working

To develop new roles and new ways of working to support the implementation of the model of care.

2.1.6 Workforce Planning and Development
To implement and monitor the agreed Workforce Strategy including developing and implementing workforce and development plans.

2.1.7 Workforce Information and Reporting
To review, update, implement and monitor the existing strategy for providing workforce information and reporting.

2.1.8 Mandatory Training
To continuously improve interventions and mechanisms to ensure compliance and quality of mandatory training.

2.1.9 Improved wellbeing through partnership
Extend Leadership, resilience and communication programmes to wider partner and stakeholder groups within the ICO including voluntary sector.

2.1.10 Valuing our workforce, paid and unpaid

- Set up an all staff conference for the 1 year anniversary of creation of ICO
- Embed shadowing for all through appraisal and objective setting

2.1.11 Well led

- Develop a Talent Management Strategy, Plan and Programme
- Creation of a Leadership and Management Hub (virtual and physical) supporting Management as a profession - that includes all leadership and management programmes and development internally and externally; Forums to share best practice; Helpful information, policies, procedures, case studies

3. Progress on Key Performance Indicators

3.1 Workforce and OD Metrics Reports
The following reports to monitor key workforce ad OD metrics for March 2016 are included.

- Appendix A – Workforce and OD Scorecard – Organisational month by month metrics for the last year to show trends.
- Appendix B – Key Metrics by Business Unit – Metrics month by month for the 4 operational Business Units for the current financial year to show trends. Those included are vacancy factor, sickness absence, staff appraisal and mandatory training.
- Appendix C – Summary of key metrics by Business Unit, Division/Department. Those included are sickness absence, staff appraisal and mandatory training. In this report sickness absence rates are for the actual month rather than the rolling year as in other reports.

Any of the key performance indicators that were outside of the agreed target range in March 2016 are highlighted in this section of the report.

3.2 The above reports are RAG rated based on targets and thresholds for 2015/2016. Appendix D shows targets and thresholds for 2016/2017 agreed by the Workforce

and OD Group. Where the targets differ from 2015/2016 details are provided below:

- Staff Sickness Absence 4.00% at 01.04.2016 reducing to 3.8% at 31.03.2017. The sickness absence rate in February 2016 was 4.04%.
- Vacancy Factor 5% for the year. The target in 2015/2016 was 4% but the current rate is C8%. The National Institute for Health and Care Excellence (NICE) guidance indicates that organizations should aim for a maximum 5% vacancy rate to accommodate operational flexibility needs.

3.3 Staff Appraisals

The appraisal compliance rate for April 2016 was 82%. As can be seen in appendix A this is a small reduction from the previous highest ever level and below our target of 90%. This rate does compare favourably with other local Trusts (see 3.8 below).

3.4 Mandatory Training

Of the nine key modules six were rated green and three were rated amber in April 2016. Overall the combined average compliance was 88% which is within target. Section 9.2.3 includes activity to in respect of mandatory training compliance.

3.5 Sickness Absence

The sickness absence rate in March 2016 was 4.10% which is within the target. The target for the end of the 2015/2016 was 4.00%. This rate is a minor increase on previous months, however the trend does show a longer term improvement and a sustained reduction to more tolerable levels. It also demonstrates the challenge in achieving the planned 3.80% target for 2016/2017. Section 6.1 includes activity in respect of sickness management action.

3.6 Vacancy Factor

The vacancy factor was 7.92% in April 2016. The vacancy factor is calculated by dividing the WTE vacancies by the WTE funded establishment. If the temporary workforce (bank and agency) plus additional hours, less reduced hours are taken into account the vacancy factor is -0.19%. This means that in April 2016 the Trust used a total workforce slightly above its WTE funded establishment. The table below shows this position by WTE and percentage.

Funded Establishment WTE	In-Post Contracted WTE	Vacancies WTE	Vacancy Factor (excluding temporary workforce, plus add hours, less reduced hours) %	Temporary workforce, plus add hours, less reduced hours WTE	Under/Over (-) Funded WTE	Vacancy Factor (Including temporary workforce, plus add hours, less reduced
5557.25	5117.05	440.21	7.92%	450.60	-10.39	-0.19%

The vacancies are covered by our temporary workforce and staff working additional hours. However it is recognised that this currently results in increased expenditure and concerns about continuity of service and quality. Actions to improve the recruitment position and agency usage are included in this report (see sections 6.7 and 6.8).

3.7 Registered Nursing Vacancy Factor for the whole Trust was 6.69%. For Community Services, Community Hospital Services, Medical Services and Surgical Services combined the Registered Nursing Vacancy Factor was 9.09% (93.87WTE)

in total. Details of workforce plans and specific recruitment and retention initiatives are included in this report.

3.8 Key Performance Indicators Benchmarking

To enable the Trust to benchmark itself with a number of local Trusts the following information was obtained for comparison. The latest comparisons available are for February 2016 and show that the Trust performs well in respect of these indicators.

	Torbay & South Devon NHS Foundation Trust	Plymouth Hospitals NHS Trust	Royal Cornwall Hospitals NHS Trust	Royal Devon & Exeter NHS Foundation Trust	Taunton & Somerset NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Sickness Absence	4.0%	4.2%	4.4%	4.1%	**3.6%**	3.7%
Appraisal Rate	82.6%	80.5%	74.3%	81.1%	**84.9%**	72.9%
Mandatory Training	88.1%	86.0%	83.6%	85.6%	**89.2%**	88.0%

3.9 Employee Relations Cases

The table below shows the number of Employee Relations cases at the Trust that entered a formal policy and received a formal warning/outcome over the periods October 2015 to December 2015 and January 2016 to March 2016. Cases are only counted once in the period the process commenced, the formal process may be on-going and span more than one quarter.

Type of Case	Total for Quarter Oct-Dec2015	Total for Quarter Jan-March 2016
Disciplinary	**8**	**5**
Grievance	**3**	**5**
Sickness Warnings	**20**	**21**
Performance Management	**3**	**2**
Unacceptable Behaviour	**1**	**1**
Whistleblowing	**0**	**0**
Suspensions	**0**	**0**
Investigations	**11**	**5**
Settlement Agreement	**0**	**1**
Employment Tribunal Claims	**0**	**1**

The table below represents the number of organisational change projects involving formal consultation and management of redeployment. The figures below do not capture the number of employees involved within each consultation process.

	Total for Quarter Oct-Dec2015	Total for Quarter Jan-March 2016
Organisational Change	2	5
No. of Employees requiring Redeployment as a result of	20	0

organisational change		

In addition to the formal processes above the following activities are taking place concurrently:

- Management of long term sickness cases that require regular reviews
- Management of short term sickness absence reviews

4. Workforce Planning

4.1 Integrated Workforce Strategy

The Workforce Redesign Network is the sub-group of the Workforce and Organisational Development Group responsible for steering and coordinating delivery of the Integrated Workforce Strategy. Guided by these groups activity in respect of the Integrated Workforce Strategy is continuing as follows:

- The proposed changes for reconfiguration of Community Services are being scoped and a developed into a workforce development plan. Crucially the plan will include skills development and how peoples jobs can be protected in accordance with the Trusts no compulsory redundancy policy.
- Changes to the workforce as part of the Urgent Care Vanguard will need to be managed in tandem with the reconfiguration of Community Services as they will affect some of the same workforce.
- The annual plan submitted to Monitor encompassed the workforce section which included the forecasted workforce numbers for the Trust. These numbers are in accordance with the original five year plans for the Trust but also include reductions in agency and bank as The Trusts permanent workforce is stabilised.
- Key to the Integrated Workforce Strategy is the development of career pathways and "growing our own". This includes the establishment of HCA apprentices, continuing development of Assistant Practitioners, an 18 month training programme for Assistant Practitioners to qualify as Registered Nurses and the use of HEE sponsored places for those Assistant Practitioners. Further work including with Higher Education Institutions is on-going to develop similar arrangements for Allied Health Professionals. More detail of progress in these areas is included in the Education and Development section 9 of this report.

4.2 Meeting the Workforce Demand/Supply

As previously reported and emphasised in 3.6 and 3.7 above the existing gap between the demand for our workforce and existing supply continues to be a challenge. As described in 4.1 above and in more detail in other parts of this report a number of initiatives are in place seeking to rectify this position.

It has been recognised and repeated on many occasions that workforce planning in the NHS has been deemed to have failed particularly in respect of the Annual Demand Forecasting Exercise, with the number of newly qualified staff identified as required not being matched by the number of training places commissioned by Health Education England.

Partly in an attempt to overcome the disparity of demand and supply, training for nurses and other health care professions excluding medical and dental staff is

moving from bursaries to a student loan system with effect from the 2017 intake. How this system will work is not yet known but the Workforce and OD Group has discussed and approved activity for proposals to be worked up including:

- Engaging directly with the Higher Education Institutions regarding training commissions and the Trusts requirements.
- Considering arrangements for how the Trust can secure the employment of those students undertaking registered training including scoping the possibility of offering:
    - A role as our students with a commitment to being employed by the Trust at the completion of training
    - Support via sponsorship or own bursary system
    - Offering paid work outside of term time
    - Providing attractive placement options across the wider health and social care community
    - Support with accommodation and travel

Given the above circumstances an assessment of the nursing vacancy factor and how the Trust will close that gap has been undertaken. The intention is to target various strategies which are included in this report which should result in the Trust reducing the vacancy gap for nursing to virtually nil over the next five years based on the following broad strategies that are discussed elsewhere in the report:

- Growing our own which will result in an increase in the number of Assistant Practitioners (AP's) going on to complete Registered Nursing Training
- Return to Nursing on an on-going basis which is likely to remain fairly static
- Sponsorship of nurse and other registered staff training
- Targeting newly qualified staff in the short term and in the longer term moving to recruiting our own student nurses as described above.
- General recruitment initiatives as described later in this report.
- The redesign of roles to fit the care model

5.0 Pay, Pensions and Expenses

5.1 Staff Expenses System

As agreed by the Workforce and OD Group the preferred option of moving to the ESR linked staff expenses system is being pursued. The two options have been reviewed and a formal proposal to move to the preferred new system will now be progressed.

5.2 Pay Award and National Insurance Changes

The Agenda for Change 1% pay award was implemented in April 2016 and at the same time the National Insurance contributions for those staff in an occupational pension scheme was no longer at a lower rate than for those staff not in an occupational pension scheme. This and a number of tax changes have led to an increase in pay queries but not at the level that might have been anticipated without the communications that were sent out to all staff.

5.3 Pensions Tax Allowances

As previously reported we have communicated to relevant staff the changes effective from the 6th April 2016 to the life time tax allowance and annual tax

allowance for pensions. Individual requests for information are being responded to and a further communication about available protections will be sent out in July 2016.

5.4 External Services

Following on-going negotiations the Trust has received confirmation from Yeovil District Hospital NHS Foundation Trust that the proposed costs of providing them with a payroll service are acceptable. The Trusts Commercial Department have developing a Heads of Terms agreement that has now been signed. The Trust will start to provide the payroll service with effect from the 1st August 2016. To enable the Trust to provide the service from the 1st August 2016 recruitment of staff is underway with a number of positions already offered.

5.5 Weekly Payroll

The weekly payroll for bank only workers has been successfully implemented. Details of progress with the numbers on the weekly payroll and submitting timesheets is included in section 6.8 of this report that provides details of the other incentives for bank workers.

6.0 Human Resources

6.1 Managing Sickness Absence

The data for sickness absence at the end of March 2016 indicates a rolling 12 month figure of 4.10%. This is marginally above the end of year target of 4%. The increase in absence figures is chiefly accounted for by a spike in short term absence rates in January and February and which follows an historical trend for that period of the year.

6.1.2 Long term sickness continues to make up the higher proportion of the overall figure and for end of March this stood at 64.61%. In respect of days lost through absence 'stress, anxiety and depression' remains the top declared category of sickness absence standing at 19.34% with MSK at 16.74%. The category of absence that causes the most number of episodes to be taken continues to be 'Colds and Flu'.

6.1.3 Notwithstanding previous statements around the fact that the current Sickness Absence Policy is in accord with good practice and is fit for purpose, both the Trade Unions and Trust management feel there is a need to review the policy. This relates to clarifying some perceived ambiguities and responding to an area of improvement identified in the 2015 Staff Survey which indicated that an above average (65% against 58%) of staff indicated that they had felt pressured to attend work when feeling unwell. This of course could be for a number of reasons including those relating to workloads and not wanting to let colleagues down and also to the application of the sickness absence management policy. This is currently being explored in discussion with staff side representatives.

6.2 Staff Friends and Family Test *(CQUIN for 2014/15)*

The Staff FFT went live in the month of February within; Corporate Services (Acute), Estates and Facilities Management, Continuing Healthcare, Community Services and Medical – community. The quantative findings are as detailed below;

		Recommendation for care or treatment		Recommendation as a place to work	
	Number of respondents	Number of staff likely or extremely likely to recommend	Number of staff unlikely or extremely unlikely to recommend	Number of staff likely or extremely likely to recommend	Number of staff unlikely or extremely unlikely to recommend
Chief Exec/Medical Director	4	4	0	4	0
Education and Development	13	12	1	10	2
Estates and Facilities	8	8	0	6	2
Finance, Performance and Information	41	36	1	30	2
Nursing and Quality	12	12	0	7	1
Hotel Services	16	16	0	14	0
Pharmacy	28	24	1	23	2
Transport	7	7	0	6	0
Workforce	16	16	0	13	1
Continuing Healthcare	2	2	0	2	0
Medical	3	3	0	3	0
Community – Southern Devon	17	14	0	13	3
Community – Torbay	40	36	0	30	13
Torbay Social Care	5	3	1	3	0

*The outstanding responses are either 'don't know' or 'neither likely or unlikely'

Once received, the comments reports will be forwarded, by directorate, to the senior manager for them to share with staff and develop any necessary action plans.

6.3 Staff Experience CQUIN 2015/16

As previously reported the staff experience CQUIN aims to improve overall staff experience through the establishment of a Multi-Agency Staff Experience Network (MASEN).

The quarter 4 objectives were as identified below;

1. To have implemented a method of recognising staff contribution, (egg. long service) which has been identified as a result of the MASEN
2. A summary of the collaborative improvement and evaluative account of the CQUIN will be undertaken.
3. A summary of the collaborative improvement and staff experience demonstrated via the staff survey results will be submitted to the CQUIN panel.
4. The panel are to receive evidence of embedded "Always Events" into usual practice for staff.

Regular quarterly monitoring with the CCG takes place and reports are made on progress to the Workforce and Organisational Development Group.

6.4 Freedom to Speak Up Guardians

As part of phase two of the 'See something, say something' initiative 9 *'Freedom to Speak Up' Guardians* were appointed at the end of January. The prime role of the Guardian is to act in a genuinely independent and impartial capacity to support staff to raise concerns. The Guardians will ensure that the voice of front line staff is heard at a senior level by reporting common themes to the Board on a regular basis.

The Guardians have been working since their appointment to develop appropriate systems and processes. The guardian service went live on 8th April 2016 and was detailed in the Staff Bulletin and latest news. The Guardians have a dedicated web page detailing the role of the guardian, who the guardians are and how to contact them, together with useful information on how to raise a concern.

In addition, training videos from Health Education England have been uploaded on to the 'See something, say something' website to provide advice in 'Raising Concerns' and 'Responding to Concerns'. Plans for further training continue to develop.

6.5 National Whistleblowing Policy

This month the final version of the overarching whistleblowing policy to be adopted by all NHS organisations was published by NHS Improvement. This comes in response to the Freedom to Speak Up review by Sir Francis QC, who concluded that whistleblowing required 'urgent attention' if staff are to play their full part in maintaining a safe and effective service for patients. A 'standard integrated policy' was one of a number of recommendations of the review. NHS Organisations are expected to adopt the policy by 31st March 2017.

In order to ensure there is a single Whistleblowing policy with sufficient detail about how the Trust will look into a concern, the Trusts local whistleblowing policy has been integrated with the national policy. The draft integrated policy has been endorsed by the Workforce and Organisational Development Group.

6.6 NHS Staff Survey 2015

Following engagement with key stakeholders, a comprehensive action plan has been developed to address those areas highlighted for development. The action

plan has been published on the intranet and communicated through the staff bulletin, together with a Staff Survey leaflet which reminds staff of the findings. The implementation of the action plan will be monitored through the Workforce and Organisational Development Group.

Where available, directorates have received local findings from the survey for them to develop individual action plans to address those specific areas identified for development.

6.7 Recruitment

6.7.1 Strategic Recruitment and Retention Group

The notes of the Strategic Recruitment and Retention group meeting on the 30th march 2016 are included as appendix E. As previously reported there are four working groups reporting into the Strategic Recruitment and retention Group. The activity of each of these groups is reported below.

6.7.2 Recruitment and Recruitment Processes Working Group

The group is continuing to meet on a regular basis. The current work activities include:

- Nursing Open Day – this took place on the 27th April 2016. Interviews were held on the day and the Trust is looking to offer positions to 26 individuals, 19 newly qualified nurses and 7 already qualified nurses. In addition 8 individuals expressed an interest in joining the Return to Nursing Practitioner Course.
- Use of Social Media - work is underway to explore how we make better use of social media as part of the advertising of the Trust and our vacancies.
- Marketing of the Trust - the Group is examining the potential for developing a range of videos.
- 'Over-recruitment' of Nurses and AHPs - A process has been developed to identify any applicants that have been interviewed and considered appointable, but for which there are insufficient vacancies in the areas for which they have applied. The process will be piloted before being rolled out across the Trust.
- Developing adverts - it has been identified that one of the delays in the recruitment process could be the quality of the advert. Advertising guidance is therefore being developed.

6.7.3 Retention Sub Group

The group is reviewing our retention and identifying reasons for why staff leave our organisation and how long after they have started in post they choose to leave and the reason. In addition information from our existing exit questionnaires has been analysed to provide a more complete picture. Only a small percentage of leavers currently complete an exit interview. Work is being carried out around revising the current system for conducting exit questionnaires/interviews and also more detailed analysis is being undertaken on the issue of registered nursing staff leaving after 1-2 years' service with the Trust. Proposals in respect of these areas will be discussed at the next sub group meeting in May.

6.7.4 Succession Planning and Role Redesign

The group has developed and agreed with the Strategic Recruitment and Retention Group that the CIPD definition of succession planning should guide the activity as follows '"the process of identifying and developing potential future leaders or senior managers, as well as individuals to fill other business-critical positions, either in the short or the long-term. In addition to training and development activities, succession planning programmes typically include the provision of practical, tailored work experience relevant for future senior or key roles".

The approach to be taken to ensure succession planning is embedded in the organisation as well as specific business critical posts' being identified was agreed as follows:

- The development of a culture, processes and systems for all staff to embed succession planning across the trust for all roles.
- That culture, processes and systems include more detailed and specific activity in respect of posts that have all or most of the following characteristics:
    - Business critical
    - Known national shortage
    - Limited internal pool of staff to replace the post
    - Specialist/narrow skill set
    - Skills and knowledge that are not easily transferable

A task and finish plan for the working group was agreed at the last Strategic Recruitment and Retention Group meeting.

6.7.5 Temporary Staffing and Agency Sub Group

The work of this Group is reported under 6.8.

6.7.6 Overseas Nurse Recruitment

Whilst the Trust continues to recruit from Europe, there has been a noticeable decrease in the numbers coming forward since the introduction of the requirement to pass the IELTS (International English Language Testing System) exam.

The Trust has decided to pursue the option of recruiting from the Philippines, as nurses are now on the Government's shortage occupation list. This means nurses from non EU countries are now able to obtain a visa to work in the UK for three years in the first instance.

There are a number of tests the Philippine nurses will need to pass before they are able to apply for a visa. Once the nurses arrive in the UK they have to pass the NMC OSCE examination and the Trust is developing a robust training programme to support them through this process. Only when they have passed this examination will they be able to register with the NMC.

A team is currently in the Philippines working with local agencies to identify and interview suitable candidates for our Trust.

6.8 Temporary Staffing

As described in this report there are a large number of initiatives aimed at reducing the Trusts reliance on its temporary workforce. The level of Bank and Agency Usage therefore remains under constant review, with the aim of decreasing the level of overall usage of temporary labour and secondly to increase the proportion of Bank as opposed to Agency. Progress on the initiatives in the use of Bank and Agency workers are included below.

As previously discussed the Trusts Finance Committee and Board have agreed a package of measures which are currently being implemented as follows:

- A weekly payroll has been implemented for bank workers that do not have substantive contracts. Of the 800 bank only workers that were offered the opportunity to be paid weekly 280 have opted to do so to date. Additional recruits who are being automatically paid weekly have increased this total to 303. Of these in the first 2 weeks of the payroll the below shows the number that submitted timesheets.

Staff Nurse (band 5)	6	10
Staff Nurse (band 6)		1
Sister/Charge Nurse (band 7		1
Assistant Practitioner (band 4)	2	1
Health Care Assistant (band 3)	1	
Health Care Assistant (band 2)	53	71
Estates and Ancillary (band 2)	14	20
Administrative and Clerical (band 2)	5	10
Physiotherapist (band 6)	1	1
Occupational Therapist (band 6)	1	1
Total	**83**	**116**

The weekly bank will continue to be reviewed and reported to the Workforce and Organisational Group to assess is effect including the existing decision not to provide the option for weekly pay to those substantive staff that also work shifts on the bank.

- Introduction of a 'Recommend a friend ' scheme to be launched in May 2016.
- Substantive staff that work a bank shift will be paid for that shift at their substantive pay point.

Further planned incentives to be implemented soon include:

- Payment of travel expenses at public transport rate for working in areas which are more than 5 miles from home
- A bonus payment for those workers who work in excess of 200 hours in a three month period
- The potential for introducing an 'early' booking bonus.

In addition the Group is reviewing rostering practices with a view to ensuring that the most expensive shifts are filled by substantive staff or through bank rather than going to agency.

6.8.1 Activity

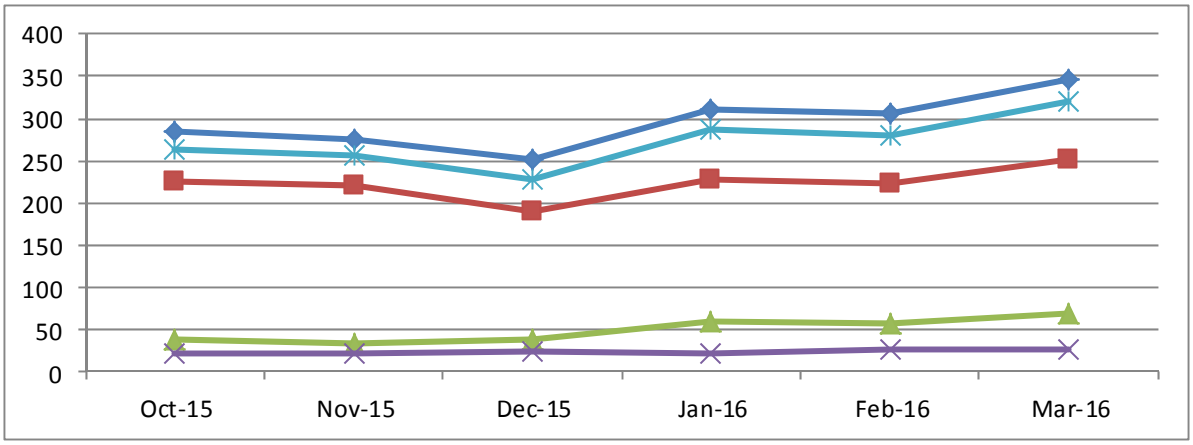
We are continuing to report to Monitor on a weekly basis on all agency shifts booked with Agencies that are not on an agreed framework or exceed the price caps. The Trust is continuing to work with other Trusts in the region to address the issue of the lack of framework agencies, meeting the price cap, operating in the South West. Whilst some agencies are now meeting the November capped rate, to date none of the framework agencies are able to meet them.

The Temporary Staffing Team continues to strive to fill the demand for shifts across the acute and community settings. In March 2016 the Temporary Staffing Team was able to fill 93% of the shifts through a combination of bank and agency. This equates to 319 WTE.

The tables below show the bank and agency usage by WTE for the whole Trust and separately for acute and community areas for the most recent months. Appendix F includes graphs for the whole year showing bank and agency usage.

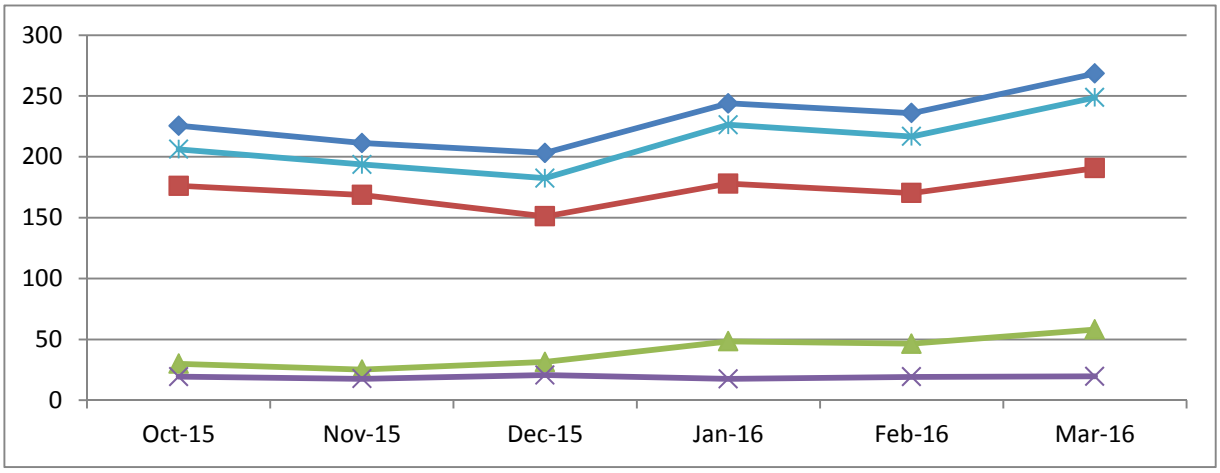
6.8.2 Bank & Agency Utilisation

Total Bank and Agency Usage TSDT - WTE



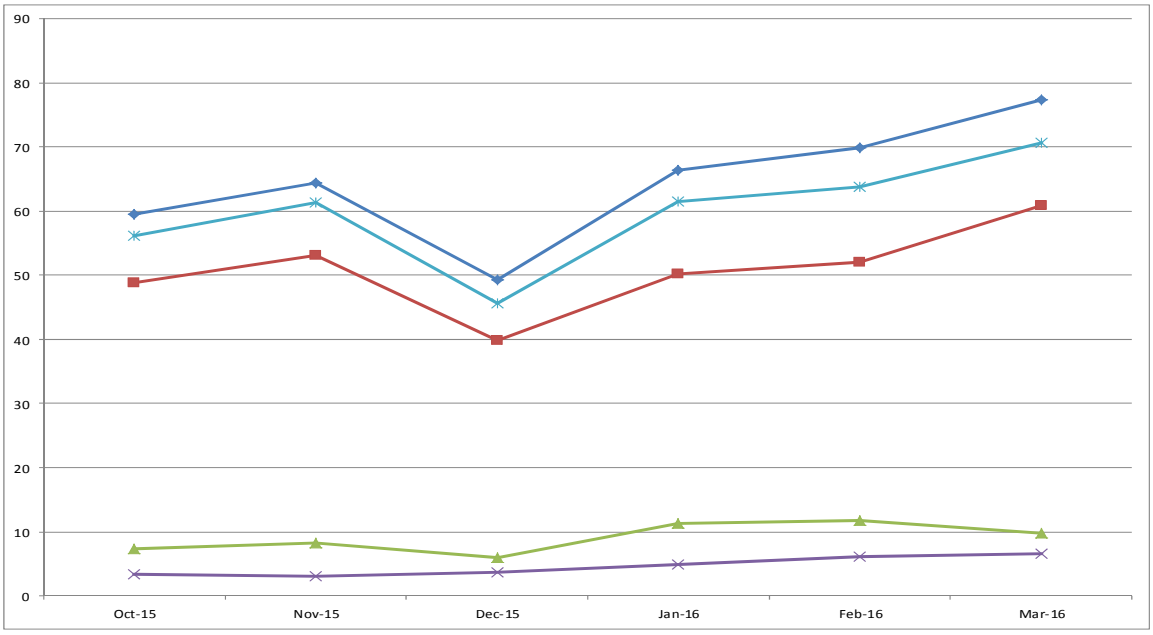
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total WTE Requested	285	276	253	310	306	346
Total WTE Covered	262	255	228	288	280	319
Total WTE covered by bank	225	222	191	228	222	252
Total WTE covered by Agency	37	33	37	60	58	68
Total WTE unassigned	23	21	24	23	25	26

Acute Hospital Bank and Agency Usage – WTE



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total WTE Requested	225	211	203	244	236	268
Total WTE Covered	206	194	182	226	217	249
Total WTE covered by bank	176	169	151	178	170	191
Total WTE covered by Agency	30	25	31	48	46	58
Total WTE unassigned	19	18	21	18	19	20

Community Hospitals Bank and Agency Usage – WTE



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total WTE Requested	60	64	49	66	70	77
Total WTE Covered	56	61	46	61	64	71
Total WTE covered by bank	49	53	40	50	52	61
Total WTE covered by Agency	7	8	6	11	12	10
Total WTE unassigned	3	3	4	5	6	7

6.9 Medical HR

6.9.1 Junior Doctor 2016 Contract

From the 3rd August 2016, new contractual arrangements will be introduced for doctors and dentists in training in hospital posts approved by the GMC/GDC for postgraduate medical and dental education.

For those doctors already in training, the new terms will be introduced as they move between contracts of employment. However, for these doctors there will be a period of transition during which pay protection arrangements will apply, depending on the stage of training reached.

Work is underway to implement the changes required locally to support the new Terms and Conditions (TCS). The largest task is to ensure that all internal rotas for Junior Doctors are compliant with the new working hour's regulations.

The Trust is required to appoint a Guardian of Safe working hours. The guardian of safe working hours is required to ensure that concerns about the safety of doctors' working hours are resolved in a timely and appropriate fashion. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by continued scrutiny of the quality of training by Health Education England (HEE).

One to one meetings are currently taking place between with department managers and clinical leads to review their rotas and make any necessary changes to meet compliance under the new contract.

The Trust has formed an assurance group to ensure organisational readiness to fully implement the requirements of the junior doctor contract. The group includes membership from the Medical Staffing Committee, Medical Education a representative on behalf of the Medical Director and Human Resources. The Junior Doctors Representatives have been offered membership which has been declined.

Human Resources have also initiated a regional Medical HR group which includes attendance from eight other Trusts from across the region to discuss and share best practice for implementing the new contract.

6.9.2 Medical Recruitment

The Trust has been successful in recruiting to the vacant consultant posts in Gastroenterology, Orthodontics, Diabetes & Endocrinology and one post in

Neurology (with two still vacant). There has also been success in recruiting to a new consultant post in GUM.

The Trust is still struggling to recruit to certain specialties and is discussing the benefits of potentially holding a Medical recruitment day at Torbay Hospital. Details of current consultant vacancies are shown below.

Grade	Specialty	Status
Consultant (new post)	Histopathology	Trying to recruit since Apr 2015, the dept are currently reviewing their options
Consultant (Two posts)	Radiology	Out to advert (trying to recruit since Dec 2015)
Consultant (replacement x2)	Stroke	Out to advert (long term vacancy since Mar 2015)
Specialty Doctor (vacant post x2)	Emergency	Out to advert (long term vacancy since Apr 2015)
Consultant (New Post)	Anaesthetics- Pain Management	Re-advertised and closes on 15th May
Consultant (New Post)	Dermatology	No applications received during latest advertisement
Consultants (replacement x2)	Neurology	Re-advertised following one successful replacement
Consultants (replacement)	Healthcare of Older People	Re-advertised and interviews on the 18th May

7.0 Occupational Health

7.1 Occupational Health

The Executive Team have approved the plan to outsource the Occupational Health service and the preferred supplier is 'Optima Health' who currently run the service for other NHS trusts including SWAST, Yeovil and Taunton. Work is now underway to start an implementation project plan to ensure a smooth transition.

8.0 Workforce and OD Systems

8.1 ICO Project Plan – ESR Merge

The merge of the two separate ESR systems is now complete with one system operating for the whole Trust. The exercise has been successful but there is still work on-going to tidy the system for example consolidating cost centres from the previous two Trusts.

8.2 ESR Input

The new electronic starters, change of circumstance and termination forms for the whole Trust were implemented at the start of February 2016. No major concerns have been raised and following further communication only the new electronic forms will be accepted after the end of March 2016.

8.3 ESR Post Merge

As detailed in the last report and discussed at the last meeting the planned strategy for ESR is being implemented and any significant developments such as moving to

electronic payslips only will be brought back to the Workforce and OD group in the first instance.

8.4 E-rostering

As last reported to the Board the Workforce and OD Group asked for the options appraisal for moving from Rosterpro to Allocate to be reviewed to be assured that option 3 was the most effective way forward. A group including Workforce and IT reviewed the options appraisal and there recommendation still to proceed with option 3 was agreed by the Workforce and OD Group. The summary of Option 3 is as follows:

Option Three – Implement a coordinated and actively managed programme of works with the ultimate aim of procuring the Allocate solution and commencing a staged implementation

This option proposes an immediate review of the current IT systems and processes across the new organisation with the purpose of standardising and simplifying within staff groups over the next year, whilst working on a comprehensive business case and project implementation plan to move to the Allocate Software.

A project group will be convened to plan the programme of work.

In the meantime Rosterpro is still very much operational and a recent new release has been tested and implemented and is operating effectively and has improved the system.

8.5 Learning Management System (LMS)/Nurse Revalidation

The contract for the Totara LMS that will also provide a nurse revalidation system has been signed, a Project Board and Project Team put in place and a project brief and project plan is being developed. The Project Board have asked the Project team to consider prioritising Nurse Revalidation. Nurse Revalidation currently operates using a semi-manual process which has successfully provided assurance that all nurses due to revalidate in April 2016 have done so. A fully electronic system will provide a more effective system as the numbers of nurses needing to revalidate increases.

9.0 Education and Development

9.1 Professional Practice

9.1.1 Cost Collection

Work is continuing on the HEE SW dictat for cost collection evidence relating to cost of providing education and training to students.

Two wards have been piloted to ensure the questions are sensible to garner evidence for ward staff mentoring, assessing and signing-off student nurses in the clinical setting. Evidence so far demonstrates parity across a medical and surgical ward. This pilot will then roll out across the acute and community setting to give a wide arena of clinical placement mentor activity.

9.1.2 Mask Fitting for pandemic outbreaks

An options appraisal paper has been agreed for Fit2Fit training. The processes have been started for that training programme to be delivered and accessed by named trainers. Education staff have delivered extra mask fitting sessions to cover the Flu Outbreak and more ward staff have also been educated in mask fitting.

9.1.3 The Foundation Degree in Healthcare programme (FdSc) for our Assistant Practitioners (Band 4s)

Scoping for the next cohort of Trainee Assistant Practitioners is under way via managers naming staff that are ready to undertake the education programme. These individuals will be given a Band 4 role on successful completion. The fees remain at £14,400 for each seconded member of staff to attain their FdSc. As in previous years it is hoped that there will be no cost to the Trust due to the input of clinical educational module deliveries being provided by the Lead for Non-Medical Education and the issuing of honorary contracts for students applying to South Devon College to undertake the FdSc programme.

Delivering educational modules and issuing honorary contracts equates to another saving this year of circa £250,000. The issuing of Honorary Contracts to individuals that are paying for themselves and are affiliated to the College, has helped the Trust save thousands per annum. However this year the number of honorary contracts has dropped due to the increase of HCA apprentices and the increase in overseas nurses and this in turn may affect the cost neutral approach of funding the FdSc programme for the band 4 role which does flex the workforce clinically.

9.1.4 Numeracy and English for nursing students

The Numeracy Pilot day was a real success. Processes are now in place for our Band 4 Assistant Practitioners to apply to Plymouth for Nurse Training and being able to APEL out of a maximum of 18 months of the 3 year Registered Nurse programme. This has now opened the door for this group of staff to become Registered Nurses. This is a key enabler in our “growing our own” strategy. Other Trusts have been in contact to find out how they can access this programme so it is transferable across the region.

9.1.5 Sponsorship for Adult Nursing

The Trust asked for 20 Sponsorship places from HEE SW to fast track our Band 4 Assistant Practitioners into adult nursing. The final figures for Sponsorship places came out this week. Plymouth University have received 35 places for sponsored students from across the Trust in Devon and Cornwall. The Trust’s allocation is 10 of those 35 which is equates to 29% of the total.

9.1.6 Non EU International recruitment

A business case for the Trust to recruit circa 70 Filipino nurses over the next few months has been agreed. There was no additional provision for the education needs of this staff group in relation to the NMC requirements of Pre Preceptorship and Preceptorship or the education or for these nurses to undertake the OSCE exams required by the NMC before issuing registration.

An Options Appraisal has been undertaken to address this issue. This will need to be monitored closely to ensure the introduction to the Trust is successful.

9.2 Vocational Training

9.2.1 Career Pathway

In accordance with the Trusts Integrated Workforce Strategy work continues on a pilot to create, develop and provide a healthcare delivery framework that is current, modern, innovative and sustainable for the future. The aims are to simplify career progression for those who want it with innovative new roles and pathways to promotion, including more part-time higher vocational education as a route into nursing to include vocational degree courses.

The intention to create consistent national standards in training should allow a flexible workforce that can operate across organisational boundaries to deliver better patient care.

We aim to simplify career progression for those who want it with innovative new roles such as a 2 year HCA apprenticeship, band 3 HCA role and pathways to promotion, including more part-time higher education as a route into nursing and other registered professions to include all levels of vocational apprenticeships.

The plan is to recruit individuals at the start of their career and we are planning an apprenticeship intake of healthcare apprentices in the new academic year for year 13 school leavers to create opportunities for Devon Studio School students including leavers from South Devon College that truly reflects the National Strategic Framework under the Talent for Care strategy – "Get in" "Get on" "Go Further".

9.2.2 Work Experience

The Employability Hub is hoping to work with Fair Train – the owner of the national Work Experience Quality Standard accreditation. They are part funded by the UK Commission for Employment and Skills and support a number of employers, learning providers and young people across the UK. Fair Train is for every organisation to have a highly trained workforce fit for the future. Their mission is to ensure that employers are able to access high quality workforce development that enhances sustainability and strengthens local societies. As we do, they believe in the benefits of work experience, not only for those who want to kick start their career, but also for employers looking to recruit the best talent and see the best results. We hope to pilot this during the summer.

9.2.3 Mandatory Training

The mandatory training compliance rates have dropped slightly in one or two areas in April 2016.

Action Plan:

- Individual and team compliance rates sent out the week commencing 18th April to all staff and managers.
- Target emails to be sent to individual staff members highlighting how to access non-compliant topics. These will be sent out at the beginning of May after April's training has been logged.
- Mandatory training reminder is to be placed in the staff bulletin.
- Compliance figures are to be sent to "Heads of Service" group and low complaint areas for example Hotel Services, Rainbow Day Nursery, and Pharmacy etc.

- Meetings will be undertaken with subject matters experts of topics where figures have decreased for example Selina Hoque (Infection Control) to discuss learning options.

The team continue to work alongside low compliant areas to offer a blend of either face to face or digital learning.

The Prevent (Healthwrap) training has been successfully implemented over the past year and the Trust is now 84% compliant. With recommendations from NHS England we are now increasing the number of staff who are required to complete this 1 hour course. This increase will only affect approximately 200 staff. The Trust lead for Prevent, Joanna Williams (Associate Director for Social Care) is responsible for ratifying this proposal.

10.0 Organisational Development (OD)

10.1 Training Needs Analysis

During May and June we will be meeting with operational service delivery team managers to undertake an analysis of their OD requirements for the coming 1-3 years.

Specific focus will be on leadership and management development and the challenges for staff at an individual and team level. This will in turn be reflected in the modules covered in all programmes across the OD and vocational training functions.

10.2 Cultural Barometer

The findings of the cultural barometer assessment in the Emergency Department have now been analysed and shared with the senior managers. In total, 43 members of staff responded equating to a 40% response rate, an increase of 18% from the barometer assessment 18 months ago. Overall there was increased level of positive responses.

The high level themes are:

Areas that scored well:

- There is commitment to quality of care within the department
- The department strives to improve the patients experience
- My colleagues and I work together for our patients

Areas for improvement:

- Experiencing respect and dignity at work
- Working in an environment where everyone counts and feels valued.

Next steps include meeting with the management team to put forward recommendations for action and appropriate interventions based on the responses received and observations carried out in the department.

10.3 Coaching Training

There are currently 19 members of staff who are being trained to become coaches within the organisation. They are all from very different professional backgrounds from many different services across the Trust, adding true diversity and experience to their learning. Their training will be complete in November and they will then become part of our internal network of coaches.

10.4 Supporting the New Model of Care

A number of facilitated team sessions are been supported by members of the OD Team including bringing together the administration teams in the Coastal locality.

10.5 Future Partnerships

A scoping exercise together with initial conversations with some of our partner organisations (including the voluntary sector) are happening to ascertain whether joint leadership programmes and courses could be created to build positive relationships and shared understandings of leaders and managers of the ICO and our partners.

10.6 Developing the Strengths-based Approach

A Strengths-based is approach is the style in which we will be working within the LMATs and across the whole Trust in all aspects of our work be it within health, social care or leadership style. It will be the golden thread which runs through all our interactions with people, both in terms of how we invest care and support in our teams and how our teams in turn invest care and support in the people they serve. Furthermore it supports the more holistic approach of 'what matters to you' moving away from 'what's the matter with you'.

This approach will also have an impact on some of the systems, processes and documentation that is already in place.

There are a number of methods and models used already in existence within the organisation that use a similar approach i.e. Guided Conversations, shared decision making and Talk Back. In order to bring these methodologies together in the spirit of a strengths-based approach OD will be working with key people and other agencies. An initial conversation has already been had with the Royal College of Physicians in how the delivery of training for shared decision making for clinicians can be aligned and underpinned with the strengths-based approach. Other training will need to be adapted to incorporate the strengths-based approach including the delivery of educational and personal effectiveness programmes.

10.7 A day in the life of

During the staff engagement programme prior to creation of ICO there was a huge amount of interest from staff when they were able to share with their colleagues at the engagement sessions which service they worked for and what their role was. It started to address different perceptions (sometime negative) of each organisation and the staff gained a greater understanding reducing barriers to change.
The Head of OD is liaising with communications to re-invigorate the catalogue and devise a wider plan of how "a day in the life of" can be incorporated into the business of the organisation.

10.8 Talent Development

At present there we don't have a robust talent development or "maximising potential" programme within the organisation. The OD aspect of The Leadership Academy are creating a conversation tool that supports the talent development

process. Once available we will incorporate but whilst this happening a plan for talent development will be created in collaboration with the succession planning activity outlined in 7.8.4 above.

11.0 Staff Welfare and Wellbeing @ Work

11.1 Staff Welfare and Well-being is now an identified sub-group of the Workforce and Organisational Group alongside Strategic Recruitment and Retention, Workforce Redesign Network and Organisational Development.

The Trust recognises that the health and wellbeing of NHS staff is a key driver for improvement to quality, innovation, productivity and prevention. The Staff Welfare and Well-being sub-group will provide direction and oversight for the health and wellbeing activities across the health community, leading by example and ensuring that the Trust can evidence its progress by providing reports to the Workforce and Organisational Development Group.

11.2 Key Staff Welfare and Well-being Workstream areas include:

- Employee appreciation and recognition
  - Blue Shield Awards
  - WOW Awards
  - Long Service Awards
  - Retirement
  - Thank you acknowledgements

- Mental Health and Wellbeing in the Workplace
  - Stress (in and outside work)
  - Feeling anxious
  - Mental health First Aiders

- Physical Health and Wellbeing in the Workplace
  - Diet
  - Smoking
  - Exercise
  - Alcohol
  - Back pain

11.3 Employee Appreciation and Recognition

This will include the annual **Blue Shield Awards** and the development of the existing **WOW Awards**.

The annual Blue Shield Awards will be continued in to 2016/17 and will form part of a wider staff appreciation and recognition agenda, including:

- Re-badging the WOW Awards into an internally promoted and administered **Customer Service Award**, enabling patients and service users to nominate staff and their teams in recognition of excellence in care provision. Bi-monthly celebratory certificate presentation events will be organised with the Chairman, Chief Executive and Executive Team to celebrate staff in receipt of these Awards.

- Developing **Long-Service Awards** – identifying staff reaching employment milestones at 25 years 35 years and over. The table below shows current achievements:

Years' service	Total	Ratio
Less than 10	3962	65.10%
10 yrs to 24	1781	29.26%
25 yrs to 34	296	4.86%
35 and over	47	0.77%
Grand Total	**6086**	**100.00%**

- Working with HR on the development of **Retirement Awards** – identifying staff approaching retirement age and developing a mechanism for recognition of retirement. The table below shows staff numbers reaching retirement age:

Current Age	Total	Ratio
Under 55	4728	77.69%
55 to 59	816	13.41%
60 to 64	425	6.98%
65 plus	117	1.92%
Grand Total	**6086**	**100.00%**

- Production of **'Thank-you'** cards for Executives and Senior Managers to be used as a means to thank, recognise and in turn incentivise staff who have gone above and beyond roles and responsibilities. The cards can be sent in a hard form through the post and also uploaded to the Staff Intranet which will have a designated page.

11.4 Mental Health and Wellbeing in the Workplace

Nationally, 37% of employees report having to take time off work because of stress, low mood, or poor mental health. In addition 68% report having gone into work at some point when experiencing poor mental health. Half of all respondents note that poor mental health is a result of a combination of problems at work and in their personal life.

The table below shows (reported) stress related absences in the Trust:

Absence Reason	Heads	Count of occasions	Calendar Days Lost	Ave Calendar Days per individual
Anxiety/stress/depression / other psychiatric illnesses	429	518	15286	35.6

Evidently many employees feel supported and good practices are in place. However, many employees do not feel confident in disclosing their needs and potentially one in five people who have reported mental health problems to their employer have experienced adverse treatment. Discrimination is a perceived and real fear for many.

An objective of the Staff Welfare and Well-being sub group is to improve support for people with poor mental health in the workplace. It is proposed that supporting people with mental health will include:

- **Developing the foundations:** Leading from the top, creating champions to lead the way, developing wellbeing, communicating a way forward
- **Building upon the foundations:** Develop a meaningful Policy, supporting and developing managers, getting the right support structures in place, creating space for wellbeing
- **Reviewing progress:** How it is going, being flexible, increasing the energy
- **Keeping the momentum going:** Getting feedback, making more change, becoming the norm

Mental health first aid training – this will teach participants how to recognise the signs and symptoms of mental health problems and to respond appropriately.

Mental health first aiders will be trained to deal with common problems like anxiety or depression, through to more urgent situations like psychosis (when somebody is no longer in touch with reality) or suicidal thoughts.

11.5 Physical Health and Wellbeing in the Workplace

On-going consultation and communication with staff at all levels will be undertaken to identify relevant workplace health issues.

Working alongside the Lifestyles team, the Staff Welfare and Well-being sub group will look at developing workplace lifestyle interventions and develop campaigns to support people to:

- Quit smoking
- Become more active
- Make healthier eating choices
- Reduce alcohol consumption
- Develop self-management techniques (including the Wellness Recovery Action Plan (WRAP))

A large proportion of (reported) absences are recorded as **back pain**. A piece of work is to be undertaken to conduct a detailed analysis of absence due to back pain (including a financial analysis) to identify the merit of having an in-house physiotherapy service to enable staff to recover and return to work as soon as possible. Initial findings for the year April 2015-March 2016 are shown in the table below:

Absence Reason	Heads	Count of occasions	Calendar Days Lost	Ave Calendar Days per individual
Back Problems	276	318	4381	15.9

11.6 Wellbeing at Work Steering Group

This group is to be re-formed. It has been suggested that the ICO Champions can act as the Steering Group for Wellbeing and this is to be discussed with them at their meeting on the 29th April 2016. In addition the group will include representatives of Staff-side, Hiblio, Lifestyles and Communications.

TSDFT Workforce and OD Scorecard 2016/2017 **Appendix A**

Apr-16

Indicator and (Target)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Bank/Agency Spend Total	£737,624	£1,590,091	£2,498,486	£3,388,102	£4,383,581	£5,430,808	£6,718,244	£7,918,436	£9,059,507	£10,494,361	£11,816,473	£13,368,816	£1,746,467
Bank Monthly	£321,918	£394,001	£366,133	£375,545	£451,147	£373,237	£522,045	£644,746	£544,710	£577,004	£554,756	£633,754	£835,496
Agency Monthly	£415,706	£458,466	£542,262	£514,071	£544,332	£673,990	£765,391	£555,446	£596,361	£857,850	£767,356	£918,589	£910,971
Staff Headcount Number	4255	4255	4262	4256	4262	4276	6089	6078	6057	6071	6069	6059	6077
Staff Establishment WTE	3866.41	3872.03	3819.94	3844.10	3855.00	3887.31	5506.99	5527.21	5524.46	5503.96	5511.78	5513.05	5557.25
Staff in Post WTE	3615.57	3599.98	3597.75	3594.88	3682.92	3638.56	5144.64	5153.82	5108.62	5128.76	5125.18	5057.48	5117.05
Cumulative Vacancies WTE	250.84	272.05	222.19	249.22	172.08	248.75	362.35	373.39	415.84	375.20	386.60	455.57	440.20
Vacancy Factor (excl temp workforce and add hours) (5% or below)	6.49%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%	6.82%	7.01%	8.26%	7.92%
Bank Usage (WTE)	144.73	172.97	155.70	165.76	204.57	166.33	185.09	223.51	243.61	240.63	239.78	266.85	296.85
Agency Usage (WTE)	58.51	81.36	65.74	47.38	44.60	92.58	53.87	98.78	124.20	107.26	115.45	144.27	132.66
Additional Hours/Reduced Hours (-) (WTE)	-6.84	-16.23	3.75	6.07	-78.25	-28.72	3.82	42.85	2.37	-33.43	-31.07	1.83	21.09
Vacancy Factor (inc temp workforce and add hours) (4% or below)	1.41%	0.88%	-0.08%	0.78%	0.03%	0.48%	2.17%	0.15%	0.83%	1.10%	1.13%	0.77%	-0.19%
Starters	20.1	19.9	16.5	24.3	32.4	48.3	70.0	59.9	23.9	53.4	62.5	39.4	48.1
Leavers	26.2	32.5	21.3	36.3	36.3	41.8	54.5	68.1	45.9	62.3	46.5	53.3	38.3
Staff Turnover Rate % (Between 10% - 14%)	10.78%	12.80%	11.00%	11.17%	11.05%	11.09%	12.79%	12.97%	13.15%	12.94%	13.09%	12.75%	12.78%
Sickness Absence Rate % (4.00% or less)	4.19%	4.18%	4.16%	4.13%	4.12%	4.12%	4.07%	4.04%	3.98%	3.99%	4.04%	4.10%	
Bradford Score % over 250 Points	12.53%	12.76%	12.38%	12.53%	12.23%	12.20%	11.62%	11.69%	10.76%	9.18%	10.68%	10.63%	
Sickness Cost	£4,288,033	£4,269,085	£4,223,943	£4,184,439	£4,172,131	£4,172,955	£6,058,810	£6,075,432	£6,042,868	£6,043,671	£6,151,402	£6,279,071	
Skill Mix (Registered/Non-registered)	54/46	54/46	54/46	54/46	54/46	54/46	55/45	55/45	55/45	55/45	55/45	55/45	55/45
Staff appraised in last year (90% or above)	83%	83%	84%	85%	85%	83%	80%	77%	78%	86%	85%	83%	82%
Age Profile - % of staff over 55 years of age	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	22.0%	22.0%	22.0%	22.0%	23.0%	22.0%	22.0%

Training and Development - Percentage of staff compliant

Information Governance Training (95% or above)	85%	85%	84%	85%	87%	87%	91%	90%	90%	90%	89%	88%	88%
Fire Training (85% or above)	82%	83%	83%	83%	84%	84%	85%	84%	86%	85%	83%	83%	82%
Child Protection L1 (90% or above)	85%	86%	86%	86%	87%	87%	92%	92%	93%	93%	93%	92%	92%
Infection Control (85% or above)	81%	81%	80%	81%	82%	82%	84%	83%	85%	84%	83%	82%	81%
Equality & Diversity (85% or above)	89%	90%	90%	90%	91%	90%	91%	92%	93%	93%	93%	93%	92%
Conflict Resolution (85% or above)	85%	87%	88%	87%	89%	87%	90%	91%	92%	92%	91%	90%	89%
Health & Safety (85% or above)	89%	88%	88%	87%	88%	86%	88%	88%	89%	89%	88%	87%	86%
Manual Handling (85% or above)	82%	83%	82%	83%	84%	84%	86%	86%	88%	87%	86%	86%	86%
Safeguarding Adults L1 (90% or above)	86%	87%	88%	88%	88%	88%	93%	93%	94%	94%	94%	93%	93%
Average Compliance	**85%**	**86%**	**85%**	**86%**	**87%**	**86%**	**89%**	**89%**	**90%**	**90%**	**89%**	**88%**	**88%**

Appendix B

OUTTURN	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Vacancy Factor % (excl temp workforce and add hours) - All ICO Staff	6.49%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%	6.82%	7.01%	8.26%	7.92%
Community BU Total													10.28%
Medicine BU Total													13.39%
Surgery BU Total													9.86%
WCD BU Total													2.30%
Vacancy Factor % (inc temp workforce and add hours) - All ICO Staff	1.41%	0.88%	-0.08%	0.78%	0.03%	0.48%	2.17%	0.15%	0.83%	1.10%	1.13%	0.77%	-0.20%
Community BU Total													3.09%
Medicine BU Total													-3.76%
Surgery BU Total													5.87%
WCD BU Total													1.47%
Sickness Absence - All ICO Staff	4.26%	4.28%	4.19%	4.16%	4.15%	4.12%	4.07%	4.04%	3.98%	3.99%	4.04%	4.10%	
Community BU Total	4.77%	5.01%	4.67%	4.54%	4.50%	4.53%	4.38%	4.43%	4.27%	4.44%	4.29%	4.39%	
Medicine BU Total	3.85%	3.87%	3.79%	3.75%	3.80%	3.85%	3.84%	3.83%	3.87%	3.94%	4.00%	4.06%	
Surgery BU Total	4.40%	4.41%	4.45%	4.47%	4.40%	4.36%	4.26%	4.19%	4.08%	4.10%	4.15%	4.15%	
WCD BU Total	3.64%	3.59%	3.57%	3.53%	3.46%	3.41%	3.27%	3.26%	3.19%	3.19%	3.24%	3.29%	
Staff Appraisals - All ICO Staff	84%	84%	86%	86%	86%	84%	80%	77%	78%	86%	85%	83%	82%
Community BU Total	84%	86%	89%	89%	86%	86%	83%	80%	85%	90%	90%	89%	88%
Medicine BU Total	84%	83%	86%	87%	86%	86%	81%	80%	76%	83%	81%	77%	76%
Surgery BU Total	83%	82%	84%	86%	90%	89%	88%	85%	86%	90%	89%	87%	87%
WCD BU Total	81%	84%	86%	85%	85%	79%	81%	80%	87%	92%	89%	86%	87%
Mandatory Training - % Completion of 9 competencies - All ICO Staff	87%	87%	87%	88%	88%	87%	89%	89%	90%	90%	89%	88%	88%
Community BU Total	93%	93%	91%	92%	92%	91%	92%	92%	93%	92%	91%	89%	89%
Medicine BU Total	83%	84%	84%	83%	86%	85%	85%	85%	85%	85%	86%	85%	84%
Surgery BU Total	85%	86%	86%	86%	87%	86%	87%	87%	88%	88%	89%	88%	88%
WCD BU Total	90%	90%	90%	90%	90%	89%	89%	89%	89%	89%	89%	89%	88%

Appendix C

Division/Directorate	Sickness	Appraisals	Training (Average)	Staff	FTE
	Mar-16	Apr-16	Apr-16	Apr-16	Apr-16
CHARITABLE FUNDS DIVISION	3.07%	64%	79%	34	20.26
Health Visiting & School Nursing	5.99%	95%	91%	104	81.43
Other Public Health Provider	7.82%	93%	91%	97	80.82
Dir - Public Health	6.89%	94%	91%	201	162.25
SD Community Services - Coastal	5.68%	85%	93%	36	29.05
SD Community Services - Moorland	0.41%	79%	86%	22	17.52
SD Community Services - Newton Abbot	5.54%	92%	87%	34	27.39
SD Community Services - Other	6.42%	86%	91%	76	59.66
SD Community Services - Totnes and Dartmouth	2.38%	80%	93%	34	29.05
Dir - SD Community Services	4.82%	85%	91%	202	162.66
TCT Community Services - Adult Social Care	1.32%	95%	91%	22	20.44
TCT Community Services - Baywide	10.31%	79%	93%	41	35.87
TCT Community Services - BEST	8.69%	75%	77%	18	13.45
TCT Community Services - Brixham Zone	8.95%	84%	87%	59	46.86
TCT Community Services - MSK	1.59%	81%	89%	39	32.60
TCT Community Services - Older Peoples Mental Health	1.02%	100%	82%	11	7.67
TCT Community Services - Other Social Care	0.97%	100%	92%	12	10.36
TCT Community Services - Paignton	5.43%	85%	85%	103	87.60
TCT Community Services - Torquay Zone	5.53%	90%	87%	148	129.64
Dir - Torbay Community Services	5.73%	87%	87%	453	384.48
COMMUNITY SERVICES DIVISION	5.77%	88%	89%	856	709.39
Dir - Chief Executive	3.66%	88%	91%	20	17.43
Dir - Education & Development	5.12%	80%	95%	93	88.13
Finance	6.22%	40%	92%	84	78.43
Health Informatics Service	5.96%	83%	93%	170	147.52
Procurement	3.49%	44%	91%	38	36.53
Dir - Finance, Performance & Information	5.70%	65%	93%	292	262.48
Dir - Medical Director	0.06%	95%	91%	30	25.08
Associated Health Professionals	3.00%	98%	97%	72	58.73
Nursing & Quality	5.58%	85%	88%	120	101.54
Dir - Nursing & Quality	4.62%	90%	91%	192	160.27
Operations	3.57%	91%	85%	24	19.29
Operations Support	6.95%	68%	91%	56	51.54
Transformation and Operational Change	1.72%	71%	84%	9	8.36
Transport	1.36%	98%	86%	74	66.35
Dir - Operations	3.75%	87%	88%	163	145.54
Dir - Pharmacy Services	3.97%	84%	89%	89	76.61
Dir - Strategy	0.64%	62%	91%	35	34.24
Dir - Workforce	2.25%	78%	93%	79	67.73
CORPORATE SERVICES DIVISION	4.31%	78%	91%	993	877.52
Estates	6.25%	75%	97%	41	40.44
Facilities Management	0.00%	69%	96%	19	17.73
Dir - Estates & Facilities	4.80%	73%	97%	60	58.17
Hotel Services - Catering	5.78%	66%	78%	73	50.27
Hotel Services - Domestic	6.18%	94%	81%	236	168.80
Hotel Services - Other	8.46%	74%	77%	73	67.19
Dir - Hotel Services	6.64%	85%	80%	382	286.27
ESTATES & FACILITIES MANAGEMENT DIVISION	6.35%	83%	82%	442	344.44
Dir - Hospital Services - Brixham	3.46%	72%	94%	30	24.25
Hospital Services - Dawlish Hospital	2.72%	79%	96%	28	24.26
Hospital Services - Teignmouth Hospital	4.15%	86%	91%	37	27.79
Dir - Hospital Services - Coastal	3.53%	83%	93%	65	52.06
Dir - Hospital Services - Dartmouth	1.05%	92%	90%	34	26.75
Dir - Hospital Services - MIU Services	4.71%	92%	93%	33	27.98
Hospital Services - Ashburton Hospital	5.53%	94%	88%	20	15.23
Hospital Services - Bovey Tracey Hospital	1.68%	83%	66%	20	15.92
Dir - Hospital Services - Moorland	3.65%	90%	77%	40	31.15
Dir - Hospital Services - Newton Abbot	5.22%	87%	87%	116	95.76
Dir - Hospital Services - Paignton	2.50%	93%	86%	61	47.13
Dir - Hospital Services - Totnes	6.77%	94%	92%	38	29.40
HOSPITAL SERVICES DIVISION	4.09%	88%	89%	417	334.46

Ind Sec Adult Social Care - Torbay	1.77%	50%	90%	10	9.52
Ind Sec In House Services LD - Torbay	7.56%	88%	84%	47	34.25
545 Dir - Independent Sector Adult Social Care - Torbay	6.36%	81%	85%	57	43.77
546 Dir - Independent Sector Health	7.40%	64%	94%	28	25.40
INDEPENDENT SECTOR DIVISION	6.73%	75%	88%	85	69.17
INTERNAL AUDIT	13.04%	80%	96%	15	14.17
Cancer Services - Medicine	22.73%	83%	78%	9	8.80
Clinical Oncology	4.45%	57%	87%	56	49.01
Haematology	0.00%	100%	58%	4	4.00
Medical Oncology	0.00%	100%	100%	5	4.23
Non Surgical Cancer Services Admin	4.03%	100%	92%	42	33.43
Palliative Care	0.00%	100%	83%	6	4.90
Ricky Grant Unit and Turner Ward	6.26%	85%	74%	75	63.55
Dir - Cancer Services - Medicine	5.62%	79%	82%	197	167.92
Care of the Elderly - Medicine	4.63%	81%	79%	102	90.80
Stroke	5.28%	70%	74%	40	37.86
Dir - Care of the Elderly - Medicine	4.82%	77%	77%	142	128.66
Dermatology	0.00%	22%	82%	15	11.29
Neurology	0.00%	100%	58%	4	3.70
Rheumatology	3.59%	67%	90%	17	14.15
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	1.70%	50%	83%	36	29.15
Dir - Emergency Services	3.89%	90%	89%	248	205.72
Diabetes and Endocrinology	3.83%	71%	90%	20	17.47
Gastroenterology	5.43%	33%	81%	77	67.93
Dir - Gastoenterology/Endocrinology- Medicine	5.09%	38%	83%	97	85.40
Admin/Support- Med Div	1.72%	85%	95%	42	38.33
General Medicine	8.64%	64%	74%	32	25.29
Medical Division HQ	0.00%	83%	85%	9	6.65
Dir - General Medicine	3.87%	79%	86%	83	70.27
Cardiology	3.29%	71%	84%	128	108.49
Respiratory	2.96%	83%	89%	72	61.48
Dir - Heart & Lung- Medicine	3.17%	74%	86%	200	169.97
MEDICAL SERVICES DIVISION	4.27%	76%	84%	1003	857.08
PMU Finance	8.27%	60%	100%	5	4.64
PMU Manufacturing	1.96%	8%	89%	52	50.57
PMU Quality Control	4.20%	49%	93%	40	38.69
PMU Sales & Marketing	9.60%	100%	93%	6	5.39
PMU Senior Team	0.00%	33%	100%	6	5.20
PMU Supply Chain	1.10%	56%	86%	19	15.29
PHARMACY DIVISION (Manufacturing)	3.16%	36%	91%	128	119.77
RESEARCH & DEVELOPMENT DIVISION	7.04%	97%	92%	41	33.75
Dir - Breast Care	7.07%	92%	94%	44	34.12
Dir - General Surgery	5.17%	84%	86%	261	218.19
Dir - Head & Neck	2.04%	91%	86%	102	76.70
Dir - Ophthalmology	1.70%	94%	88%	120	102.91
Dir - Surgical Division	4.29%	96%	91%	71	64.82
Dir - Theatres, Anaesthetics and ICU	5.06%	80%	89%	407	360.97
Dir - Trauma and Orthopaedics	2.72%	94%	89%	164	140.40
SURGICAL SERVICES DIVISION	4.20%	87%	88%	1169	998.12
Child Health Med, Mgmt and Misc Specialty	3.18%	100%	88%	59	52.81
Paediatric	4.72%	85%	91%	95	74.50
Dir - Child Health	4.08%	88%	90%	154	127.31
Dir - Lab Medicine	5.98%	82%	89%	115	102.01
Gynaecology	7.81%	77%	89%	39	29.35
Midwifery	3.14%	90%	89%	131	102.77
O&G Medical and Management	6.04%	95%	79%	44	38.48
Dir - Obs & Gynae	4.55%	88%	87%	214	170.59
Dir - Radiology & Imaging	1.61%	87%	91%	129	109.82
Dir - Sexual Health	2.33%	64%	87%	41	30.87
Dir - Therapies	1.95%	91%	87%	211	174.45
Medical Electronics	0.63%	93%	88%	16	15.34
Women's, Children's & Diagnostics	2.80%	82%	97%	14	13.00
Dir - Women's, Children's and Diagnostics	1.59%	88%	92%	30	28.34
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.46%	87%	88%	894	743.37
ICO Grand Total	**4.53%**	**82%**	88%	**6077**	**5121.52**

Appendix D

Workforce Metrics Targets 2016/2017

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Factor	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Staff Turnover	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%	10% - 14%
Sickness Absence	4.00%	4.00%	4.00%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.80%
Staff Appraisals	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Mandatory Training												
Child Protection	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Safeguarding Adults	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Fire	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Infection Control	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Information Governance	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Health and Safety	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Conflict Resolution	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Manual Handling	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
Equality and Diversity	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

Workforce Metrics RAG Thresholds 2016/2017

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy Factor	7%+	7%+	7%+	7%+	7%+	7%+	7%+	7%+	7%+	7%+	7%+	7%+
	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%	5%-6.9%
	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%	0%-4.9%
Staff Turnover	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+	16.1%+
	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%	0%-7.99%
	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%	14.1%-16%
	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%	8%-9.9%
	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%	10%-14%
Mandatory Training												
Information Governance	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%	0%-84%
	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%	85%-94%
	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%	95%-100%
Safeguarding	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%
	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%
	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%
All Others	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%	0%-74%
	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%	75%-84%
	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%	85%-100%
Sickness Absence	4.01%+	4.01%+	4.01%+	3.91%+	3.91%+	3.91%+	3.91%+	3.91%+	3.91%+	3.91%+	3.91%+	3.91%+
	3.50%-4.00%	3.50%-4.00%	3.50%-4.00%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%	3.50%-3.90%
	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%	0.00%-3.49%
Staff Appraisals	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%	0%-79%
	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%	80%-89%
	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%	90%-100%

Torbay and South Devon NHS
NHS Foundation Trust

STRATEGIC RECRUITMENT & RETENTION GROUP
Wednesday 30th March 2016

In attendance: Vicki Sheen (Deputising for Emma Mays)
Phil Waite, Jane Gidman, Heather Parker
Chris Edworthy, Jo Williams, Julie Turnbull

Apologies: Ali Evans, Lorraine Webber, Ian Leather
Trish Spruce, Emma Mays, Matt Halkes,
Chris Morey, Mike Mogford, Martin Ringrose, Tracey Collins

Action

1. Notes of Previous Meeting

The notes of the meeting held on 10th February 2016 were agreed as a correct record.

2. Matters Arising

a) Social Care Representative - Jo Williams was welcomed to the Group. In addition Jo will attend the Recruitment & Recruitment Processes Working Group as and when time allows.

b) Overtime Payments - it would appear there was some confusion regarding overtime payments and offering shifts at enhanced rates.

Julie advised that a paper was going to the next Finance Committee, which following a decision would enable some clarity and criteria to be put around these arrangements.

c) Agenda Carried Forward - it was noted that at the previous meeting it had been agreed that these would be picked up at the Recruitment & Recruitment Processes Working Group.

d) 'Over' Recruitment of Shortage Posts - Julie advised that this was being picked up by the Recruitment & Recruitment Processes Working Group.

A flow chart had been drafted for the 'front end' of the process and was currently with the ADNs and Head of Therapies for comments.

- A meeting was arranged with Workforce/Finance and HR to look at the back end process to support this from an operational perspective.

- As part of that meeting the concerns of the Group would be worked through, in particular:-

  - from a financial perspective the ability to move across budgets
  - from a HR perspective the ability to give more flexibility to move people to fill posts across the Trust without the need to re-advertise

JG/TC

e) Overseas Nurses – Jane Gidman raised concerns that there was no additional funding to support the educational input required for the 70 overseas nurses from the Philippines.

It was agreed that Jane would discuss this with Tracey Collins

3. Succession Planning & Role Redesign

Phil presented the report for this Group which was endorsed by the Group.

4. Recruitment & Recruitment Processes Working Group

Julie advised that the Group had met twice since the last meeting and identified a number of work-streams, in particular the Group was focussing on the development of a 'promotional' video, which could be linked to all job adverts to 'sell' the benefits of living and working in South Devon. Julie was arranging a meeting with Matt Halkes to take this forward. **JT/MH**

This was seen as the part of a phased programme to develop videos for posts that were hard to recruit.

The Group supported this initiative and recognised that this was expedites as soon as possible.

Julie also provided an update on the Nurse Open Days planned for 27 & 28 April 2016.

5. Retention Working Group

The Group noted the notes of the meeting on 3rd March 2016. Heather Parker advised the Exit Questionnaire was currently being revised and would be piloted within WCD&T Division.

6. Agency & Temporary Staffing Working Group

The minutes of the first meeting of 22nd March 2016 were noted.

Julie advised that she would be taking on the lead responsibility of this group.

Julie advised that a paper was being discussed at the Finance Committee regarding a number of initiatives to reduce bank and agency spend.

7. International Recruitment

Julie informed the Group that as a result of the visit to the Philippines two recruitment agencies had been appointed. The companies were now actively advertising.

Julie agreed to update the Group at the next meeting.

8. Date of Next Meeting

Wednesday 20th April 11.00am to 12.00pm in The Executive Meeting Room.

9. Future Meeting Dates

Wednesday 8 June 11am to 12pm, Executive Meeting Room
Wednesday 10 August 11am to 12pm, Executive Meeting Room
Wednesday 12 October 11am to 12pm, Executive Meeting Room

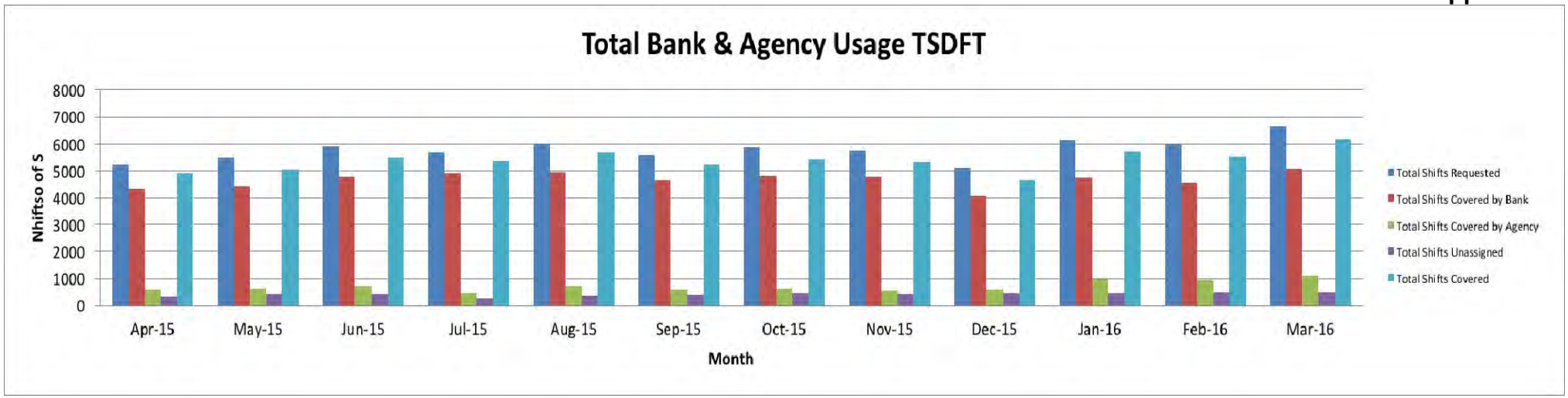
Circulation:-

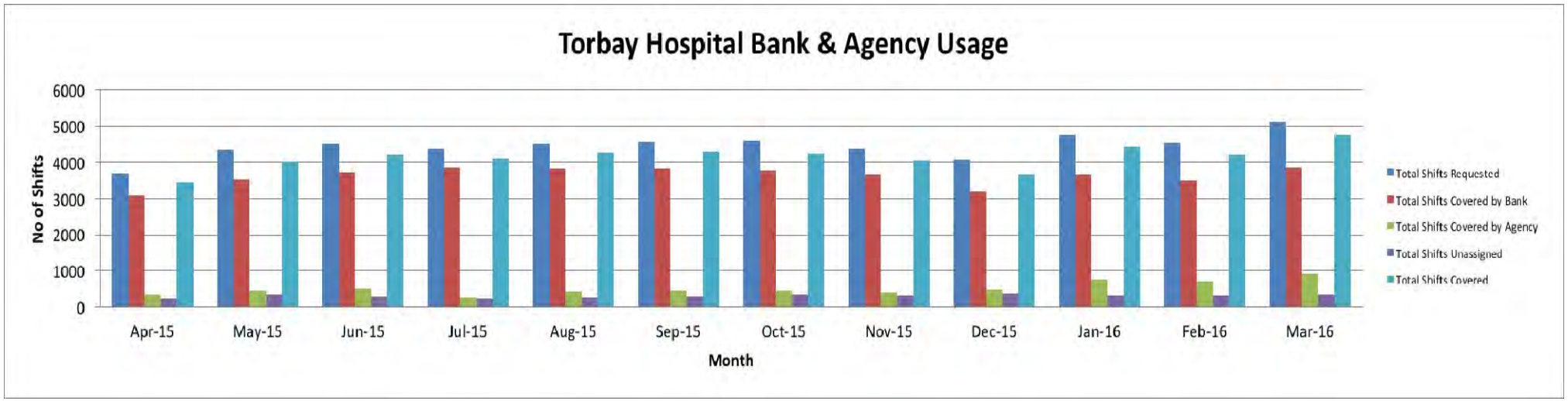
Martin Ringrose	Tracey Collins	Emma Mays
Liz Storey	Chris Edworthy	Sonja Manton
Julie Turnbull	Cathy Williams	Jo Williams
Phil Waite	Shelly Machin	Lorraine Webber
Heather Parker	Sharon Boyne	

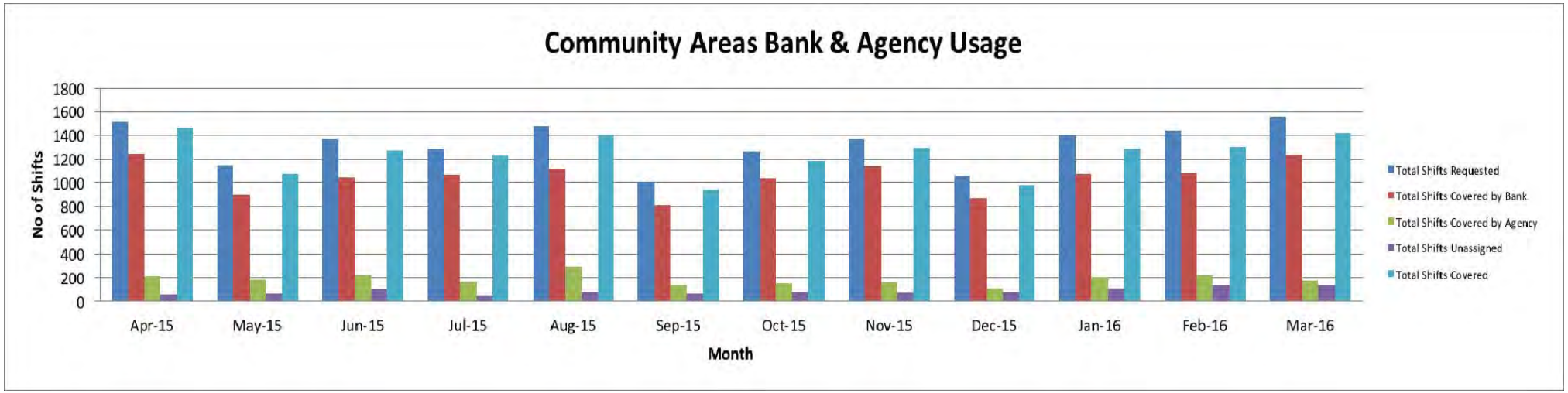
Sub-Group Members
Information only:-

Ian Leather
Sally Simpson
Mike Mogford
Alison Evans
Sarah Burns
Chris Morey

Lisa Statham


Total Bank & Agency Usage TSDFT
Nhiftso of S
8000
7000
6000
5000
4000
3000
2000
1000
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Month
Total Shifts Requested
Total Shifts Covered by Bank
Total Shifts Covered by Agency
Total Shifts Unassigned
Total Shifts Covered


Torbay Hospital Bank & Agency Usage
No of Shifts
6000
5000
4000
3000
2000
1000
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Month
Total Shifts Requested
Total Shifts Covered by Bank
Total Shifts Covered by Agency
Total Shifts Unassigned
Total Shifts Covered


Community Areas Bank & Agency Usage
No of Shifts
1800
1600
1400
1200
1000
800
600
400
200
0
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Month
Total Shifts Requested
Total Shifts Covered by Bank
Total Shifts Covered by Agency
Total Shifts Unassigned
Total Shifts Covered

REPORT SUMMARY SHEET

Meeting Date:	25th May 2016
Title:	Estates and Facilities Management, Medical Devices and Health and Safety Key Performance Indicators: Exception report for November and December 2015.
Lead Director:	Director of Estates and Commercial Development
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:
To provide assurance to the Board on compliance with legislation, standards and regulatory requirements, and to provide information on the assessed level of risk and management of same for Board consideration.

Key Issues/Risks

- Both the community Estates maintenance provider and the Trust team are still finding the urgent estates response target a challenge. An action plan is in place for both providers with a view to an improvement in performance by the end of Quarter 1 2016.
- Compliance with fire safety requirements remains a challenge, with fire safety audits identifying a specific issue due to door wedges in the operational areas. A communications strategy has been developed and implemented including a new BuZZ video, to improve staff awareness and improve performance. A new look at the process and procedures around fire management is in process with a view to strengthening ownership by the operational team, actions and assurance in this area.
- Although displaying no pattern across the organisation, minor harm collision and manual handling incidents have increased in April 2016. The H&S team will keep a watching brief on this.

Recommendations:
The Trust Board is asked to consider the assurance provided within this report and to advise if further action is required.

Summary of ED Challenge/Discussion:
The performance of fire indicators were discussed at length particularly in relation to CQC feedback, on required improvements in action planning, evacuation drills and record keeping at a local level. The Executive were provided with assurance that the whole assessment, audit and action planning process is under review by the new head of function and that a more resilient process will be put in place to include assurance and escalation of required actions. In addition to the assurance provided by the Director of Estates the Executive received additional assurance of compliance from a letter dated May 2016 from the local fire service our regulatory and enforcing authority on the organisations safety regarding fire and its compliance with the Fire Regulatory and Reform Order 2005 (enclosed)

Executives and Non-executives to emphasise the message about wedging fire doors open through line management accountabilities and safety walkarounds/Board walkarounds.

Internal/External Engagement including Public, Patient and Governor Involvement:
Governor sits on the Capital Infrastructure and Environment Group (CIEG) – (previously workstream 5).

Equality and Diversity Implications:
The Disability Awareness Action Group (DAAG) considers and is involved in all EFM development proposals.

PUBLIC

Report to:	Trust Board
Date:	April 2016
Report From:	Director of Estates & Commercial Development
Report Title:	Estates and Facilities Management Key Performance Indicators: Exception report

1. EFM Performance report for April 2016

For the year April 2016 – March 2017 the Estates and Facilities Performance report for the acute and community setting has, where appropriate, been combined. Revised indicators have been agreed accordingly based on outturn and efficiency target as appropriate.

Table 1 below identifies performance for April for EFM against the new performance criteria. Appropriate explanation and action to a resolution, is shown in Table 2 overleaf.

Table 1 April 2016 Scorecard Indicator

Green ✓	Amber !	Red ✘

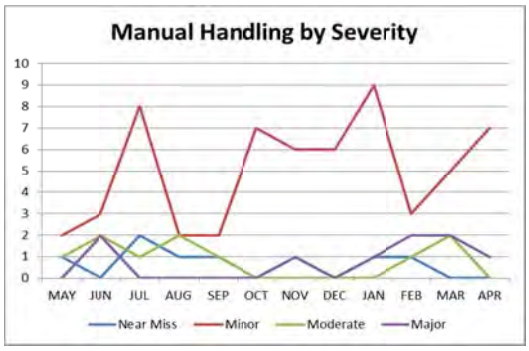
Setting	no	Red Indicators of Concern for April 2016		April 2016 Position
Acute	1.1b	PPM (Estates) % success against plan		✘
Acute	1.1g	% of Estates Reactive work resolved within target : Urgent 1-4 days		✘
Community	1.2g	% of Estates Reactive work resolved within target : Urgent 1-4 days		✘
Trust (H&S)	4.1	Number of RIDDOR Incidents		✘
Trust (H&S)	4.3	Non-patient incidents resulting in minor harm		✘
Acute	5.6	% of Compliant Fire Audits		✘

	Table 2: Areas with Specific Cause for Concern	**Anticipated timeline for improvement**
Acute	1.1b PPM (Estates) % success against plan	
	Performance of this indicator has improved during April 2016 but is not yet up to standard. Work is continuing on the relative prioritisation of work and the distribution and allocation of staff to meet demands. The department are catching up on previous months PPMs not completed due to an abnormally high amount of sickness. Work will continue to drive this indicator forward in the coming months.	June 2016
Acute	1.1g % of Estates Reactive work resolved within target - <1-4 Days (Urgent)[	
	See above	Quarter 1 2016- 17
Community	2.1g % of Estates Reactive work resolved within target - <1-4 Days (Urgent)	
	See above	Quarter 1 2016- 17

Trust (H&S)	9.1	Number of RIDDOR Incidents	
	Four of the eight related to slips trips and falls were reported in month three were on external surfaces, two on Hospital property but with no common cause. There is no pattern to the other reported incidents.		May 2016
Trust (H&S)	9.3	Non-patient incidents resulting in minor harm	
	During April there has been an increase in minor incidents resulting from manual handling and collision incidents. The Health and Safety team will continue to monitor the situation.		May 2016
Fire (Acute)	10.5	% of Compliant Fire Audits	
	This month 3 local audits were carried out with 66% being compliant. Disappointingly all non compliance areas were failures on fire doors being wedged open unnecessarily. Staff awareness continues to be raised at all training sessions and when conducting the audits, however there is an issue with ensuring the actions have been taken by the operational teams as this issue remains unresolved. Therefore an improvement plan is in the process of being developed to train a central group of risk assessors/auditors to ensure the resilience of EFM staff and to ensure that actions are monitored and escalated to ensure that improvement takes place. From the 1st April, the Head of the newly formed Safety, Security and Emergency Planning team will complete a review of the function and process which will lead to a more resilient and assured process regarding to fire compliance.		Quarter one 2016-2017

Health and Safety Performance exception

There has been an increase in minor harm incidents in manual handling and collisions for April 2016. Of the 7 minor harm incidents related to manual handling in April 2016, 5 were patient handling events with no obvious trends and 8 were collisions, 6 of which involved a stationary object. There is no pattern except for people not looking where they are going, possibly related to the use of mobile phones. Trends are seen in the graphs below.



	Area			Target	Monthly Performance												Current year to date (Complete Months)		Risk Threshold			
	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	RAG Thresholds			
	Estates (Acute Setting)																					
1.1a	Number of PPM items planned per month			Variable	968													968				
1.1b	PPM (Estates) % success against plan			95%	74%												95%	74%	R<85%	A85-94%	G>95%	
1.1c	Planned Maintenance request access denied.			0	0												0	0	R≤5	A3-4	G≤2	
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	118													118				
1.1e		Emergency – P1	<2 Hour	95%	98%												95%	98%	R<90%	A90-94%	G≥95%	
1.1f		Urgent – P2	Total Requests	Variable	269													269				
1.1g		Urgent – P2	<1- 4 Days	95%	83%												95%	83%	R<90%	A90-94%	G≥95%	
1.1h		Routine – P3 + P4	Total Requests	Variable	298													298				
1.1i		Routine – P3 + P4	<7- 30 Days	90%	88%												90%	88%	R<85%	A85-89%	G≥90%	
	Estates (Community Setting)																					
1.2a	Number of PPM items planned per month			Variable	244													244				
1.2b	PPM (Estates) % success against plan			95%	93%												95%	93%	R<85%	A85-94%	G>95%	
1.2c	Planned Maintenance request access denied.			0	0												0	0	R≤5	A3-4	G≤2	
1.2d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	11													11				
1.2e		Emergency – P1	<2 Hour	95%	100%												95%	100%	R≤89%	A90-94%	G≥95%	
1.2f			Total Requests	Variable	47													47				
1.2g		Urgent – P2	<1- 4 Days	95%	81%												100%	81%	R≤89%	A90-94%	G≥95%	
1.2h		Routine – P3 + P4	Total Requests	Variable	122													122				
1.2i		Routine – P3 + P4	<7- 30 Days	90%	93%												100%	93%	R<85%	A85-89%	G≥90%	
	Estates (All Trust)																					
1.3	Number of Estates Internal Critical Failures			0	0												0	0	R1	-	G0	
	Facilities (Acute Setting)																					
2.1	Compliance Very High Risk Cleaning Audit			98%	100%												98%	100%	R<95%	A95-97%	G≥98%	
2.2	Compliance High Risk Cleaning Audit			95%	97%												95%	97%	R≤89%	A90-94%	G≥95%	
2.3	Compliance Significant Risk Cleaning Audit			85%	99%												85%	99%	R<80%	A80-84%	G≥85%	
2.4	Compliance Low Risk Cleaning Audit			75%	99%												75%	99%	R<70%	A70-74%	G≥75%	
	Facilities (Community Setting)																					
2.5	Compliance Very High Risk Cleaning Audit			98%	100%												98%	100%	R<95%	A95-97%	G≥98%	
2.6	Compliance High Risk Cleaning Audit			95%	99%												95%	99%	R≤89%	A90-94%	G≥95%	
2.7	Compliance Significant Risk Cleaning Audit			85%	99%												85%	99%	R<80%	A80-84%	G≥85%	
2.8	Compliance Low Risk Cleaning Audit			75%	100%												75%	100%	R<70%	A70-74%	G≥75%	
	Facilities (All Trust)																					
2.9	No. of Environmental (food hygiene/Waste) Events			0	0												0	0	R1	-	G0	
	Waste (All Trust)																					

3.1	Total Tonnage per month all waste streams	176	176												146	149	R≥160	A147-159	G≤146	
3.2	% of Total tonnage Recycled Waste	38%	38%												38%	38%	R≤27%	A28-33%	G≥38%	
3.3	% of Total tonnage Landfill Waste	40%	38%												40%	38%	R≥46%	A41-45%	G≤40%	
3.4	% of Total tonnage of Clinical Non-Burn waste	18%	24%												18%	24%	R≥25%	A19-24%	G≤18%	
3.5	% of Total tonnage of Clinical Burn waste	11%	11%												11%	11%	R≥16%	A12-15%	G≤11%	
3.6	% of Total tonnage of Clinical Offensive waste	10%	12%												10%	12%	R≤5%	A6-9%	G≥10%	R>13%
3.7	% of Compliant Waste Audits	85%	100%												100%	100%	R<80%	A80-84%	G≥85%	
3.8	% Compliance of Statutory Waste Audits	95%	100%												100%	100%	R≤89%	A90-94%	G≥95%	
	Waste (Community Setting)																			
3.9	Number of Waste Audits undertaken per month	10	10												10	10	R≤5	A6 - 7	G≥8	
	Waste (Acute Setting)																			
3.10	Number of Waste Audits undertaken per month	6	6												6	6	R≤4	A5	G≥6	
	Health & Safety (All Trust)																			
4.1	Number of RIDDOR Incidents	3	8												3	8	R≤6	A3-5	G≤3	
4.2	Number of days lost (due to incidents in month)	74	45												74	45	R>84	A78-84	G<78	
4.3	Non-patient incidents resulting in minor harm	35	42												35	42	R>39	A36-39	G<36	
4.4	Non-patient incidents resulting in moderate harm	3	2												3	2	R>6	A4-6	G<4	
4.5	Number of near misses	20	27												20	27	R<15	A15-19	G≥20	
4.6	% of Staff receiving H & S training in month	85%	86%												85%	86%	R<80%	A80-84%	G≥85%	
	Fire (All Trust)																			
5.1	% of Staff receiving Fire Safety training in month	85%	82%												85%	82%	R<80%	A80-84%	G≥85%	
5.2	Number of fire alarm activations	9	7												9	7	R≥14	A10-13	G≤9	
5.3	Fire alarm activations attended by the Fire Service	2	1												2	1	R≥5	A3-4	G≤2	
5.4	No. of Fires	0	0												0	0	R1	-	G0	
	Fire (Acute Setting)																			
5.5	No of Fire Audits undertaken	6	3												6	3	R<3	A5-3	G≤6	
5.6	% of Compliant Fire Audits	85%	66%												85%	66%	R<80%	A80-84%	G≥85%	
5.7	% Fire Safety Risk Assessments (Reform Order) in date	95%	95%												95%	95%	R≤89%	A90-94%	G≥95%	
	Fire (Community Setting)																			
5.8	No of Fire Audits undertaken	8	12												8	12	R≤5	A7-6	G≥8	
5.9	% of Compliant Fire Audits	85%	100%												85%	100%	R<80%	A80-84%	G≥85%	
5.10	% Fire Safety Risk Assessments (Reform Order) in date	95%	100%												95%	100%	R≤89%	A90-94%	G≥95%	

DEVON & SOMERSET
FIRE & RESCUE SERVICE

LT Howell MBA BEng(Hons) FIFireE FRSA
Chief Fire Officer

Mr D Morris
Fire Safety and Emergency Planning Manager
Estates Department
Torbay Hospital
Newton Road
Torquay
TQ2 7AA

Western Command
Devon South Group
Torquay Headquarters
Newton Road
Torquay
Devon
TQ2 7AD

Your ref :
Our ref : BL144823/KB
Website : www.dsfire.gov.uk

Date : 11 May 2016
Please ask for : Rod Schneider
Email : rschneider@dsfire.gov.uk

Telephone : 01803 653700
Fax : 01803 653740
Direct Telephone : 01803 653719

Dear Mr Morris

Regulatory Reform (Fire Safety) Order 2005
Torbay Hospital, Newton Road, Torquay, TQ2 7AA

Further to your recent enquiry I can confirm that Torbay Hospital being a high life risk premises has undergone several announced and unannounced inspections, audits and familiarisation visits over the last 24 months.

I would advise you that the Fire Authority have found no serious issues or relevancy issues with regard to non-compliance of the above legislation in any areas of the Hospital grounds including the medical wards.

Due to the size, use and nature of the premises problems will always arise in such large and complex premises. Where issues have been discovered they have always been dealt with swiftly with the full co-operation of the officers involved.

Furthermore, the co-operation or assistance between the two authorities has been excellent and has been of value to both parties.

Yours sincerely

Rod Schneider
Station Manager